

CERTIFICATE OF DEATH

Reg. Dist. No. 08804

08805

1. PLACE OF DEATH a. COUNTY Somerset WICOMICO MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland Somerset b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Princess Anne SALISBURY		c. LENGTH OF STAY IN 1b 35 years	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION PENINSULA GENERAL HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) JAMES First ALFORD Middle ALFORD Last		4. DATE OF DEATH Month 6 Day 5 Year 1967	
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1/1/1899
9. AGE (In years last birthday) 68 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY Retired	11. BIRTHPLACE (State or foreign country) RICHMOND, VA
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME JAME ALFORD	
14. MOTHER'S MAIDEN NAME MAKY		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO.		17. INFORMANT Lena Alford, Princess Anne, Md	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic myocarditis 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Hypertension			INTERVAL BETWEEN ONSET AND DEATH 6 mths
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from May 20th 1965 to June 7th 1967 , that I last saw the deceased alive on June 4th 1967 , and that death occurred at 6:30 PM , from the causes and on the date stated above.			
ACTUAL SIGNATURE Eldon G. Markman M.D.		ADDRESS (Street, city or town, state) Princess Anne, Md.	
DATE SIGNED			
PHYSICIAN'S NAME (Type) Eldon G. Markman		Princess Anne, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 6/7/67	22c. NAME OF CEMETERY OR CREMATORY John Wesley	22d. LOCATION (City, town, or county) (State) Princess Anne, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE William H. James Jr.		ADDRESS Princess Anne, Md	
24a. REC'D BY REGISTRAR JUN 12 1967		24b. REGISTRAR'S SIGNATURE Charles Judge	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

08806

08805

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>W.D.R.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SALISBURY</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BERLIN</u>	
c. LENGTH OF STAY IN 1b <u>2 yrs</u>		d. STREET ADDRESS <u>23rd</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>SPRINGHILL NURSING HOME</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>RUTH</u> Middle <u>H.</u> Last <u>AYDELOTTE</u>		4. DATE OF DEATH Month <u>JUNE</u> Day <u>28</u> Year <u>1967</u>	
5. SEX <u>FEM</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>AUG 22 1900</u>
9. AGE (In years lost birthday) yrs. <u>66</u>		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE OWN HOME</u>		10b. KIND OF BUSINESS OR INDUSTRY <u> </u>	
11. BIRTHPLACE (County & State, or foreign country) <u>WILLARDS MD</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>ERNEST WILKINS</u>		14. MOTHER'S MAIDEN NAME <u>MANNIE COOPER</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>220-01-7525D</u>	
17. INFORMANT <u>MRS. MILDRED GREEN</u>		Address <u>BERLIN MD</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bacterial pneumonia</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) <u>Cardiovascular renal disease</u> DUE TO (c) <u> </u>		INTERVAL BETWEEN ONSET AND DEATH <u> </u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		20. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	
20a. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u> </u>		20b. TIME OF INJURY Month, Day, Year Hour <u> </u> a.m. <u> </u> p.m. <u>19</u>	
20c. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		20d. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>	
20e. (City or town) <u> </u>		20f. (County) <u> </u>	
20g. (State) <u> </u>		21. I certify that (I) (this hospital) attended the deceased from <u>April</u> , 19 <u>67</u> , to <u>6-28</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>6-27</u> , 19 <u>67</u> , and that death occurred at <u> </u> M, from causes on and on the date stated above.	
22a. SIGNATURE <u>Philip A. Tustey</u>		22b. DATE SIGNED <u>6-28-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Philip A. Tustey</u>		22d. ADDRESS <u> </u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>7-1-67</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>EVERGREEN</u>		23d. LOCATION (City or Town) <u>BERLIN</u>	
23e. (County) <u>W.D.R.</u>		23f. (State) <u>MD</u>	
24. FUNERAL DIRECTOR <u>Anna R. Burbage</u>		25. REC'D BY REGISTRAR <u>JUL 5 1967</u>	
26. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		27. REGISTRAR'S NAME <u> </u>	

02806

02806

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and immediately, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH									
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
08807					08806				
1. PLACE OF DEATH					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)				
a. COUNTY		Wicomico			b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b		
		MARYLAND			Salisbury		Life Time		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)					d. STREET ADDRESS			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
Peninsula General Hospital					R F D				
3. NAME OF DECEASED (Type or print)					4. DATE OF DEATH				
First Middle Last					Month Day Year				
Kenneth Ballard					June 4 1967				
5. SEX		6. COLOR OR RACE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH		9. AGE (In years last birthday) yrs.	
male		Colored				I/15/1914		53	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
Machines				Maryland State College		Maryland		U S A	
13. FATHER'S NAME					14. MOTHER'S MAIDEN NAME				
Benjamin Ballard					Ellen Tilghman				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT Address				
					Ardella Ballard, Princess Anne, Md				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)								INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY:									
IMMEDIATE CAUSE (a)									
177X DUE TO									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.									
(b) Adenocarcinoma Prostate									
(c)									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
19									
21. I certify that (I) (this hospital) attended the deceased from _____, 19____ to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that death occurred at 2:37 P.M. from causes and on the date stated above.									
22a. SIGNATURE					22b. DATE SIGNED				
William B Long									
22c. PHYSICIAN'S NAME (Type)					22d. ADDRESS				
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)		
Burial			6/7/67		John Wesley		Princess Anne, Md		
24. FUNERAL DIRECTOR					25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		
William H. [Signature]					DATE JUN 8 1967		Charles Judge		

50830

CHIEF OF DEPT.

[Faint, mostly illegible text and markings across the page, possibly bleed-through from the reverse side.]

[Handwritten signature or name at the bottom of the page.]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

80

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VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

08808

CERTIFICATE OF DEATH

10220

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Worcester</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. LENGTH OF STAY IN 1b <u>BISHOPVILLE</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Peninsula General Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Richard W. Banks</u>		4. DATE OF DEATH <u>June 25</u> 19 <u>67</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JULY 12, 1891</u>
9. AGE (In years last birthday) <u>75</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RET. CARPENTER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>DELAWARE</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>JAMES H. BANKS</u>		14. MOTHER'S MAIDEN NAME <u>MARIA BANKS</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <u>22-169078</u>	
17. INFORMANT <u>ORNA D. BANKS</u>		Address <u>BISHOPVILLE, MD</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>cardiac decompensation</u> DUE TO (b) <u>arteriosclerotic heart disease</u> DUE TO (c) <u>generalized arteriosclerosis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>4200</u> <u>4</u> yrs <u>4</u> yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>6/16</u> , 19 <u>67</u> , to <u>6/25</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>6/25</u> , 19 <u>67</u> , and that death occurred at <u>7:55</u> P, from causes on and on the date stated above.			
22a. SIGNATURE <u>John G. Bulkeley</u>		22b. DATE SIGNED <u>6/25/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>John G. Bulkeley</u>		22d. ADDRESS <u>M.D. ATTENDING PHYS. MED. DIRECTOR STAFF PHYS.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>6-28-67</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>ROXANA CEMETERY</u>		23d. LOCATION (City or town) (County) (State) <u>ROXANA SUSSEX, DELA.</u>	
24. FUNERAL DIRECTOR <u>A. Douglas Nelson</u>		25a. REC'D BY REGISTRAR <u>JUL 11 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>Frankford Del.</u>		25c. REGISTRAR'S SIGNATURE <u>Frankford Del.</u>	

00230

RECEIVED OF DEPT.

RECEIVED OF DEPT. OF THE ARMY
WASHINGTON, D. C. 20315
OFFICE OF THE ADJUTANT GENERAL
OFFICE OF THE ADJUTANT GENERAL
OFFICE OF THE ADJUTANT GENERAL

RECEIVED OF DEPT. OF THE ARMY
WASHINGTON, D. C. 20315
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OFFICE OF THE ADJUTANT GENERAL

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove section papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 5-63

<div style="text-align: center;"> MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH </div>											
1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Hebron</u> c. LENGTH OF STAY IN lb <u>9 Yrs.</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Rt., # 1</u>						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Hebron</u> d. STREET ADDRESS <u>Rt., #1</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <u>WILLARD THOMAS BANKS, Sr.</u>						4. DATE OF DEATH Month <u>6</u> Day <u>20</u> Year <u>1967</u>					
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>6-5-1901</u>		9. AGE (In years last birthday) <u>66</u> yrs. IF UNDER 1 YEAR: Months <u> </u> Days <u> </u> IF UNDER 24 HRS.: Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Machinist</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Pants Mfrs.</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Maryland, Wicomico</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>Louis Banks</u>						14. MOTHER'S MAIDEN NAME <u>Ella Taylor</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>321-03-8991</u>		17. INFORMANT <u>Mrs. Frances R. Banks, See sec 2</u>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial infarction (thrombosis)</u> <u>11201</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>coronary atherosclerosis</u> DUE TO (c) <u> </u>										INTERVAL BETWEEN ONSET AND DEATH <u>1201</u> years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Diabetes mellitus</u>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>Jan 1963</u> to <u>June 1967</u> , that (I) (we) last saw the deceased alive on <u>March 4 1967</u> , and that death occurred at <u>12A</u> M, from the causes and on the date stated above.											
22a. SIGNATURE <u>Robert T. Adkins</u> M.D.						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>6-21-1967</u>			
22c. PHYSICIAN'S NAME (Type) <u>Dr. Robert T. Adkins</u>						22d. ADDRESS <u>Fruitland, Maryland</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>6-23-1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Sp. Hill Mem. Gardens</u>		23d. LOCATION (City, town or county) (State) <u>Hebron, Maryland</u>					
24. FUNERAL DIRECTOR'S SIGNATURE <u>Hill Funeral Home Salisbury, Maryland</u>						25a. REC'D BY REGISTRAR DATE <u>JUN 26 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

MEDICAL CERTIFICATION

08303

Myocardial infarction (thrombotic)
secondary to atherosclerosis

Dr. J. H. Miller

Dr. J. H. Miller

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>SOMERSET</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SALISBURY</u>		c. LENGTH OF STAY IN 1b <u>2 WEEKS.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>PENINSULA GEN. HOSP.</u>		e. STREET ADDRESS <u>MAIN ROAD</u>	
3. NAME OF DECEASED (Type or print) <u>ADA</u>		4. DATE OF DEATH Month <u>6</u> Day <u>17</u> Year <u>1967</u>	
5. SEX <u>7</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6-24-1892</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEHOLD</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>HOUSEHOLD</u>	11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>
13. FATHER'S NAME <u>CALVIN BOZMAN</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>UNKNOWN</u>	
17. INFORMANT <u>MRS ETHEL MARRINER</u>		Address <u>2153 PRINCESS ANNE MD</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchial pneumonia.</u> <u>442X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cardiovascular renal disease</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Fracture right femur</u>			INTERVAL BETWEEN ONSET AND DEATH
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input checked="" type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Fell at home</u>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>6-3</u> 19 <u>67</u> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>
20f. (City or town) <u>Princess Anne, Somerset, Md</u>		(County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Philip A. Instey</u>		22. DATE SIGNED <u>6-15-67</u>	
EXAMINER'S NAME (Type) <u>Ph. A. Instey</u>		M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
Address (Street, city, town, or county)			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>6-20-67</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>BEECHWOOD CEMETERY</u>		23d. LOCATION (City, town or county) (State) <u>PRINCESS ANNE SOM MD</u>	
24. FUNERAL DIRECTOR <u>Levy Webster</u>		ADDRESS <u>2153 PRINCESS ANNE MD</u>	
25a. REC'D BY REGISTRAR <u>DAVID L. 1 1967</u>		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

07830

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 24 hours after death.

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

08811

08809

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE Maryland b. COUNTY Wicomico			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Salisbury				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Peninsula General Hospital				d. STREET ADDRESS 205 Powell Ave.			
3. NAME OF DECEASED (Type or print) Milton Allen Bradley				4. DATE OF DEATH Month June Day 9 Year 1967			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH July 2, 1895	
9. AGE (In years last birthday) 71 yrs.		IF UNDER 1 YEAR Months 0 Days 0		IF UNDER 24 HRS. Hours 0 Min. 0		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Brick layer				10b. KIND OF BUSINESS OR INDUSTRY Masonry		11. BIRTHPLACE (County & State, or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? USA				13. FATHER'S NAME John Bradley			
14. MOTHER'S MAIDEN NAME Martha Wilson				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes			
16. SOCIAL SECURITY NO. WW 1 313-03-4696				17. INFORMANT Address Mr. Fred Bradley Riverton, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Post-operative hemorrhage 5400 DUE TO (b) Subtotal gastrectomy for Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) Chronic bleeding ulcer							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour 5:24 e.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 5:24 19 67 , to 6:19 19 67 , that (I) (we) last saw the deceased alive on 6/13/1967 , and that death occurred at 6:19 P.M., from the causes and on the date stated above.							
22a. SIGNATURE H. H. Briele				22b. DATE SIGNED 12-7-67			
22c. PHYSICIAN'S NAME (Type) H. H. Briele				22d. ADDRESS Medical Center			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 6/13/1967		23c. NAME OF CEMETERY OR CREMATORY Riverton Cemetery		23d. LOCATION (City, town or county) (State) Riverton, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Thomas F. Wallace				25. REC'D BY REGISTRAR JUN 14 1967			
25b. REGISTRAR'S SIGNATURE Thomas F. Wallace				25c. REGISTRAR'S ADDRESS Salisbury, Md.			

24111

STATE OF MONTANA

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Office of

Land

Division

Helena

Montana

Helena

State of Montana

Department of the Interior

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

08812

08810

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pittsville (Rural) 8211	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Peninsula General Hospital		d. STREET ADDRESS Box 57	
3. NAME OF DECEASED (Type or print) Norma Catherine BRADLEY		4. DATE OF DEATH JUNE 19 1967	
5. SEX FEMALE	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 29, 1944
9. AGE (In years last birthday) 22 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) at home		10b. KIND OF BUSINESS OR INDUSTRY at home	
11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Edgar L. Hammond		14. MOTHER'S MAIDEN NAME Mary Smack	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO.	
17. INFORMANT William S. Bradley III		Address Same as #2	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) URemia 757.3 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Chronic pyelonephritis (c) Bilateral vesico-urteral reflux			INTERVAL BETWEEN ONSET AND DEATH 1 yr. 10 yrs 22 yrs.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 6-16-67 , 19 67 , to 6-19-67 19 67 , that (I) (we) last saw the deceased alive on 6-19-67 19 67 , and that death occurred at 9:50 P M, from causes and on the date stated above.			
22a. SIGNATURE Raymond M. You		22b. DATE SIGNED 6-19-67	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 6/22/1967	23c. NAME OF CEMETERY OR CREMATORY Wicomico Mem. Park	23d. LOCATION (City or Town) (County) (State) Salisbury, Md.
24. FUNERAL DIRECTOR Thomas F. Wallace		25a. REC'D BY REGISTRAR JUN 22 1967	
ADDRESS Salisbury, Md.		25b. REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove coffin papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

00313

CERTIFICATE OF DEATH

WEST VIRGINIA STATE BOARD OF HEALTH

1914

Name of Deceased		Age		Sex		Race		Color		Religion		Marital Status		Occupation		Cause of Death		Date of Death		Place of Death		Signature of Physician		Signature of Registrar		Signature of Witness	

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

08813

08811

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Talbot	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. LENGTH OF STAY in 1b 3 mo. 18 days	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Neavitt		d. STREET ADDRESS Box #3	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Deer's Head State Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Roland Middle Bridges Last Bridges		4. DATE OF DEATH Month June Day 9 Year 1967	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept 15, 1895
9. AGE (In years lost birthday) yrs. 71		IF UNDER 1 YEAR Months 7 Days 1 Hours 1 Min.	IF UNDER 24 HRS. Hours 1 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Waterman		10b. KIND OF BUSINESS OR INDUSTRY Seafood	11. BIRTHPLACE (County & State, or foreign country) Talbot County, Maryland
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Daniel Bridges	
14. MOTHER'S MAIDEN NAME Delia Jones		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No	
16. SOCIAL SECURITY NO. 216 - 12 - 7157		17. INFORMANT Mrs. Annabelle H. Bridges, Neavitt, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia 491X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) Cerebral thrombosis			INTERVAL BETWEEN ONSET AND DEATH 3 days
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour 19 p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from Feb. 22, 1967 to June 9, 1967 , that (I) (we) lost the deceased on June 9, 1967 , and that death occurred at 6:15 P.M. from causes on and on the date stated above.			
22a. SIGNATURE L. V. Maldve		22b. DATE SIGNED June 10, 1967	
22c. PHYSICIAN'S NAME (Type) L. V. Maldve, M. D.		22d. ADDRESS Deer's Head State Hospital, Salisbury, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF June 12, 1967	23c. NAME OF CEMETERY OR CREMATORY Neavitt Cemetery	23d. LOCATION (City or Town) (County) (State) Neavitt, Maryland
24. FUNERAL DIRECTOR Harison E. Leonard, St. Michael Md.		25a. REC'D BY REGISTRAR JUN 14 1967	25b. REGISTRAR'S SIGNATURE Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

03813

ENTRANCE OF DEATH

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Item #9 Film #G390 6/23/67 pc

08814

CERTIFICATE OF DEATH

08812

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Del</u> b. COUNTY <u>Sussex</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>				c. LENGTH OF STAY IN TB		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Delmar</u> 463			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Peninsula General Hospital</u>				d. STREET ADDRESS <u>700 Del. Ave.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>SHIRLEY</u> Middle <u>Lee</u> Last <u>Brown</u>				4. DATE OF DEATH Month <u>June</u> Day <u>15</u> Year <u>1967</u>					
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		B. DATE OF BIRTH <u>Dec. 29, 1922</u> 48 yrs.			
9. AGE (In years last birthday) <u>44</u> yrs.		IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min.		IF UNDER 24 HRS. Hours <u>0</u> Min.					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Yarn</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>DuPont Co</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>			
12. CITIZEN OF WHAT COUNTRY? <u>US</u>									
13. FATHER'S NAME <u>Lewis Adkins</u>				14. MOTHER'S MAIDEN NAME <u>Edith Pope</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>—</u> (If yes give war or dates of service)				16. SOCIAL SECURITY NO. <u>215-16-3925</u>		17. INFORMANT <u>Oscar C. Brown</u> Address <u>Delmar Del</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>170X</u> DUE TO <u>Metastasis from carcinoma of breast</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>—</u> DUE TO <u>—</u> (c) <u>—</u>								INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town) (County) (State)									
21. I certify that (I) (this hospital) attended the deceased from <u>5-25</u> , 19 <u>67</u> , to <u>6-15</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>6-15</u> , 19 <u>67</u> , and that death occurred at <u>7 A</u> M, from causes and on the date stated above.									
22a. SIGNATURE <u>Richard E. Hughes</u>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>6/18/67</u>			
22c. PHYSICIAN'S NAME (Type) <u>RICHARD E. Hughes</u>				22d. ADDRESS <u>MEDICAL CENTER, SALISBURY, MD.</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>6/18/67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>St. Stephens</u>		23d. LOCATION (City or Town) (County) (State) <u>Delmar Sussex Del.</u>			
24. FUNERAL DIRECTOR <u>William Marvel</u>				ADDRESS <u>Delmar Del</u>		25a. REC'D BY REGISTRAR <u>Juanes yuge</u>			
25b. REGISTRAR'S SIGNATURE				DATE <u>JUN 21 1967</u>					

1330

TO THE
DIRECTOR
OF THE
BUREAU OF
THE
NAVY
WASHINGTON
D.C.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. They please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
08815 CERTIFICATE OF DEATH 08813

1. PLACE OF DEATH a. COUNTY Wicomico b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury c. LENGTH OF STAY IN 1b Salisbury d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Peninsula General Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury d. STREET ADDRESS R.D. #1, Kingswood Dr. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) LISA KAY CAUSEY		4. DATE OF DEATH Month June Day 12 Year 1967	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 24, 1967
9. AGE (In years last birthday) 0 yrs.		IF UNDER 1 YEAR Months 7 Days 50	IF UNDER 24 HRS. Hours 1 Min. 50
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none		10b. KIND OF BUSINESS OR INDUSTRY none	
11. BIRTHPLACE (County & State, or foreign country) Salisbury, Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John Wesley Causey		14. MOTHER'S MAIDEN NAME Charlotte Ann Truitt	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. Mr. John W. Causey (Father) R.D. #1, Kingswood Dr., Salisbury, Md.	
17. INFORMANT Mr. John W. Causey (Father) R.D. #1, Kingswood Dr., Salisbury, Md.		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Osteogenesis Imperfecta, cong. 7583 DUE TO (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Prematurity	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) N/A	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) N/A		20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. 11:40	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Salisbury, Maryland	
20f. (City or town) Salisbury, Maryland		20g. (County) Wicomico	
20h. (State) Maryland		21. I certify that (I) (this hospital) attended the deceased from April 24, 1967 , to 6/12, 1967 , that (I) (we) last saw the deceased alive on 6/12, 1967 , and that death occurred at 11:40 , from the causes and on the date stated above.	
22a. SIGNATURE D. G. Anderson, M.D.		22b. DATE SIGNED June 13/1967	
22c. PHYSICIAN'S NAME (Type) D. G. Anderson, M. D.		22d. ADDRESS Medical Center, Salisbury, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF June 13, 1967	
23c. NAME OF CEMETERY OR CREMATORY Wicomico Memorial Park		23d. LOCATION (City, town or county) Salisbury, Maryland	
24. FUNERAL DIRECTOR HOLLOWAY & COMPANY, SALISBURY, MARYLAND		25a. REC'D BY REGISTRAR JUN 15 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge		25c. REGISTRAR'S NAME Charles Judge	

00010

CAUSEY

John Wesley Causey

D. E. Anderson, M. D.

June 12, 1967

WILLIAMS & COMPANY, CALIFORNIA, WYOMING

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. In any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/66

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MARYLAND STATE DEPARTMENT OF HEALTH

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08816

08816

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Fruitland,</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Peninsula General Hospital</u>		d. STREET ADDRESS <u>Moore Ave</u>	
3. NAME OF DECEASED (Type or print) <u>Benjamin Franklin Christopher</u>		4. DATE OF DEATH Month <u>6</u> Day <u>18</u> Year <u>1967</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 3, 1899</u>
9. AGE (In years last birthday) <u>78</u> yrs.		10. IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Transit worker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Maryland</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.</u>	
13. FATHER'S NAME <u>John R. Christopher</u>		14. MOTHER'S MAIDEN NAME <u>Bridgett Gorman</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes; no, or unknown) (If yes give war or dates of service) <u>yes War 1</u>		16. SOCIAL SECURITY NO. <u>16-000000000</u>	
17. INFORMANT <u>Mrs. C. Ethel Christopher;</u>		Address <u>Fruitland Maryland</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> DUE TO (b) <u>Generalized arteriosclerosis</u> DUE TO (c) <u>last</u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Philip A. Insley</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>Philip A. Insley</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22. DATE SIGNED <u>6-18-67</u>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
Address (Street, city, town, or county)			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>6/21/1967</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Baltimore National</u>		23d. LOCATION (City or Town) (County) (State) <u>Baltimore, Maryland</u>	
24. FUNERAL DIRECTOR <u>James Herman</u>		ADDRESS <u>Princess Anne</u>	
25a. REC'D BY REGISTRAR DATE <u>JUN 20 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
08817 CERTIFICATE OF DEATH 08817

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS <u>526 W. ISABELLA ST</u>	
3. NAME OF DECEASED (Type or print) <u>John Robert Church</u>		4. DATE OF DEATH <u>6 - 17 1967</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>AA</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4-6-1875</u>
9. AGE (In years last birthday) <u>92</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		11. BIRTHPLACE (County & State, or foreign country) <u>Quantico</u>	
10b. KIND OF BUSINESS OR INDUSTRY		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>James Church</u>		14. MOTHER'S MAIDEN NAME <u>Sallie Dennis</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Rachel Church</u>		Address <u>Salisbury 526 W. ISABELLA ST</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Broad pneumonia</u> <u>491X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <u>5 days</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Arteriosclerotic heart disease</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>6-14</u> , 19 <u>67</u> , to <u>6-17</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>6-17</u> , 19 <u>67</u> , and that death occurred at <u>M</u> , from the causes and on the date stated above.			
22a. SIGNATURE <u>L. V. Sohler</u> M.D.		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>L. V. Sohler MD</u>		22d. ADDRESS	
23a. BURIAL, CREMATION, REMIVAL (Specify)	23b. DATE THEREOF <u>6-22-67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Quantico</u>	23d. LOCATION (City, town or county) (State) <u>Md.</u>
24. FUNERAL DIRECTOR <u>Loretta B. Jolley</u>		25a. REC'D BY REGISTRAR <u>JUL 7 1967</u>	
ADDRESS <u>Jersey Rd #2 Salisbury, Md.</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

11339

[Faint, mostly illegible handwritten text, possibly bleed-through from the reverse side of the page.]

6-14 at 67

[Handwritten signature]
V. V. Scholer MD

[Faint, mostly illegible handwritten text at the bottom of the page.]

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

08818

CERTIFICATE OF DEATH

08814

1. PLACE OF DEATH a. COUNTY Wicomico <div style="text-align: right;">MARYLAND</div>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury			c. LENGTH OF STAY IN 1b 12 Days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Peninsula General Hospital				d. STREET ADDRESS 419 Dogwood Dr.,		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) <div style="text-align: center;">First Middle Last FRANCIS ELAZAR COOK</div>				4. DATE OF DEATH <div style="text-align: center;">Month Day Year June 17 1967</div>				
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 11-17-1905		
9. AGE (In years last birthday) 61 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.		11. BIRTHPLACE (County & State, or foreign country) Windsor, Conn.		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) District Mgr. Suburban				10b. KIND OF BUSINESS OR INDUSTRY Gas Propane Co.		11. BIRTHPLACE (County & State, or foreign country) Windsor, Conn.		
13. FATHER'S NAME John Cook				14. MOTHER'S MAIDEN NAME Jennie White				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes		16. SOCIAL SECURITY NO. 442-07-8802		17. INFORMANT Address Mrs. Cecil B. Cook see sec.2				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarct DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c)						INTERVAL BETWEEN ONSET AND DEATH 12 days		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 6-5 , 19 67 , to 6-17 , 19 67 , that (I) (we) last saw the deceased alive on 6-17 , 19 67 and that death occurred at 2:15 M, from causes and on the date stated above.								
22a. SIGNATURE Wilber R. Ellis Jr.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 6-17-67		
22c. PHYSICIAN'S NAME (Type) Dr. Wilber R. Ellis Jr.				22d. ADDRESS Salisbury, Maryland				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 6-20-1967		23c. NAME OF CEMETERY OR CREMATORY Wicomico Memorial Park		23d. LOCATION (City or Town) (County) (State) Salisbury, Maryland		
24. FUNERAL DIRECTOR Hill Funeral Home Salisbury, Maryland				25a. REC'D BY REGISTRAR JUN 21 1967		25b. REGISTRAR'S SIGNATURE Charles Judge		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1917-1918

BUDGET OF THE DEPARTMENT OF AGRICULTURE

21230

Item	1917-1918	1916-1917
Salaries and wages	1,000,000	950,000
Travel	50,000	40,000
Postage and printing	100,000	90,000
Telephone	20,000	15,000
Electricity	10,000	8,000
Gas	5,000	4,000
Water	3,000	2,000
Food and clothing	10,000	8,000
Medical and dental	5,000	4,000
Funeral expenses	1,000	800
Gratuities	1,000	800
Interest on debt	100,000	90,000
Depreciation	10,000	8,000
Insurance	5,000	4,000
Losses and damages	1,000	800
Contingencies	10,000	8,000
Unexpended balance	10,000	8,000
Total	1,334,000	1,284,800

RECEIVED
JAN 10 1918
U.S. DEPT. OF AGRICULTURE
WASHINGTON, D.C.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

FOR STATE
HEALTH DEPT.

08819

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08815

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Delmar (Rural)</u>				c. LENGTH OF STAY IN 1b <u>22.1</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>U.S. 13A</u>				e. STREET ADDRESS <u>203 Carrollton Avenue</u>			
3. NAME OF DECEASED (Type or print) First <u>HILDA</u> Middle <u>MAE</u> Last <u>COOPER</u>				4. DATE OF DEATH Month <u>JUNE</u> Day <u>7</u> Year <u>1967</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>November 8, 1927</u>	
9. AGE (In years last birthday) yrs. <u>39</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Seamstress</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Shirt Factory</u>		11. BIRTHPLACE (State or foreign country) <u>Salisbury, Maryland</u>	
13. FATHER'S NAME <u>Charles H. Donoway</u>				14. MOTHER'S MAIDEN NAME <u>Mary Florence White</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>213-22-8877</u>		17. INFORMANT <u>Miss Patsy Mae Cooper (Daughter)</u> <u>203 Carrollton Ave., Salisbury, Maryland</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Crushed chest</u> 8/20 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Interval between onset and death</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Struck by truck</u>			
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>12:15</u> <u>PM</u> <u>6/7</u> <u>1967</u>				20d. INJURY OCCURRED <u>2</u> While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Highway</u>	
20f. (City or town) (County) (State) <u>Wicomico County, Md.</u>				21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input checked="" type="checkbox"/>			
ACTUAL SIGNATURE EXAMINER'S NAME (Type) <u>Earl L. Royer, M.D.</u> <u>409 Camden Ave., Salisbury, Md.</u>				22. DATE SIGNED <u>June 8 / 1967</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>June 9, 1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Wicomico Memorial Park</u>		23d. LOCATION (City or Town) (County) (State) <u>Salisbury, Maryland</u>	
24. FUNERAL DIRECTOR <u>HOLLOWAY & COMPANY, SALISBURY, MARYLAND</u>				25a. REC'D BY REGISTRAR DATE <u>JUN 9 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

71510

THE STATE OF

NEW YORK

IN SENATE

JANUARY 1, 1902

REPORT OF THE

COMMISSIONER OF THE

LAND OFFICE

ALBANY

STATE OF NEW YORK

ALBANY

January 1, 1902

FOR STATE HEALTH DEPT

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 Item #7 Film #G390 7/6/67 pc MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08820

08818

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Eden		c. LENGTH OF STAY IN lb Unknown Eden	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Upper Ferry Road		d. STREET ADDRESS Upper Ferry Road	
3. NAME OF DECEASED (Type or print) CHARLES First Middle Last		4. DATE OF DEATH 6-23-67 Month Day Year	
5. SEX Male	6. COLOR OR RACE AA	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11-6-1893
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LABORER		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) AMERICA'S GEORGIA		12. CITIZEN OF WHAT COUNTRY? US	
13. FATHER'S NAME BEN LEE		14. MOTHER'S MAIDEN NAME UNKNOWN	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO. 216-16-7725	
17. INFORMANT HERGER		Address HUNTER	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion. 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerotic heart disease. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH sudden years
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Earl L. Royer, M.D. EXAMINER'S NAME (Type) 409 Camden Ave., Salisbury, Md.		22. DATE SIGNED June 26, 1967	
23a. BURIAL, CREMATION, or REMOVAL (Specify)	23b. DATE THEREOF 6/27/67	23c. NAME OF CEMETERY OR CREMATORY Greenwood Memorial	23d. LOCATION (City or Town) (County) (State) Salisbury, Wicomico, Md.
24. FUNERAL DIRECTOR Booker West Funeral Home, Salisbury, Md.		25a. REC'D BY REGISTRAR JUN 30 1967	25b. REGISTRAR'S SIGNATURE Charles Judge

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[Handwritten signature]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

08821

08819

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Worcester</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Snow Hill</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Peninsula General Hospital</u>		d. STREET ADDRESS <u>2312</u>	
3. NAME OF DECEASED (Type or print) <u>Edward</u>		4. DATE OF DEATH Month <u>June</u> Day <u>20</u> Year <u>1967</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <u>April 15, 1903</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Canning Co.</u>	9. AGE (In years last birthday) <u>64</u> yrs.
11. BIRTHPLACE (County & State, or foreign country) <u>Snow Hill Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Unknown</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>220280489</u>	
17. INFORMANT <u>Gladys Leadbolt, Snow Hill, Md.</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Terminal Carcinoma of Maxillary Sinus</u> DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>6-15</u> , 19 <u>67</u> , to <u>6-20</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>6-20</u> , 19 <u>67</u> , and that death occurred at <u>6:50</u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>Nabil F. Warsal</u>		22b. DATE SIGNED <u>6-20-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>NABIL F. WARSAL</u>		22d. ADDRESS <u>Peninsula Gen. Hosp.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>June 23, 1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>MT. Zion Baptist</u>	23d. LOCATION (City or Town) (County) (State) <u>Snow Hill Md.</u>
24. FUNERAL DIRECTOR <u>Norman F. Morris, Snow Hill, Md.</u>		25a. REC'D BY REGISTRAR <u>DATE JUN 22 1967</u>	25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death.
Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

08822

CERTIFICATE OF DEATH

08820

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Somerset	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Princess Anne	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Peninsula General Hospital		d. STREET ADDRESS Beckford Ave	
3. NAME OF DECEASED (Type or print) First Charles Middle Dennis Last Dennis		4. DATE OF DEATH Month JUNE Day 3 Year 19 67	
5. SEX MALE	6. COLOR OR RACE NEGRO	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6/15/1871
9. AGE (In years last birthday) 95 yrs.		10. IF UNDER 1 YEAR Months 3 Days 19 Hours 67 Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY Retired	
11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Grayson Dennis		14. MOTHER'S MAIDEN NAME Sarah E. Dennis	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Mrs Hattie Dennis Princess Anne, Md		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia 334X DUE TO Multiple strokes (b) Arteriosclerosis cerebro vascular disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) Heart		INTERVAL BETWEEN ONSET AND DEATH 2 days Years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 5/21/67 to 6/3/67 , that (I) (we) last saw the deceased alive on 6/3/67 and that death occurred at 11:00 M, from causes and on the date stated above.			
22a. SIGNATURE [Signature]		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 6/10/67	
23c. NAME OF CEMETERY OR CREMATORY John Wesley		23d. LOCATION (City or Town) (County) (State) Princess Anne, Md	
24. FUNERAL DIRECTOR William H. James Jr. Princess Anne, Md		25. REC'D BY REGISTRAR JUN 14 1967	
26. REGISTRAR'S SIGNATURE [Signature]		27. REGISTRAR'S SIGNATURE [Signature]	

08333

THE STATE OF TEXAS

County of ...

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

08823

CERTIFICATE OF DEATH

08821

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. LENGTH OF STAY IN 1b 21 days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Deer's Head State Hospital		e. STREET ADDRESS 719 Moore Street	
3. NAME OF DECEASED (Type or print) First Hattie Middle Mae Last Dennis		4. DATE OF DEATH Month June Day 26 Year 19 67	
5. SEX Female	6. COLOR OR RACE Colored	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 12, 1899
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) yrs. 67
11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME George Teagle		14. MOTHER'S MAIDEN NAME Lannie Showell	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO.	
17. INFORMANT Richard Dennis		Address 719 Moore St. Salis Md	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bilateral bronchopneumonia 491X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic cardiovascular disease, Decompensated (c)			INTERVAL BETWEEN ONSET AND DEATH 3 days 1 year
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from June 5 , 19 67 , to June 26 , 19 67 , that (I) (we) last saw the deceased alive on June 26 , 19 67 , and that death occurred at 11:55 A.M. from causes and on the date stated above.			
22a. SIGNATURE L. V. Maldve, M. D.		22b. DATE SIGNED 6/26/67	
22c. PHYSICIAN'S NAME (Type) L. V. Maldve, M. D.		22d. ADDRESS Deer's Head Hospital; Salisbury, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 7/2/1967	23c. NAME OF CEMETERY OR CREMATORY Green Acres	23d. LOCATION (City or Town) (County) (State) Salisbury Wicomico Md.
24. FUNERAL DIRECTOR Clinton E. Stewart		25. REC'D BY REGISTRAR 30 1967	
25a. REGISTRAR'S SIGNATURE Charles Judge		25b. REGISTRAR'S SIGNATURE	

02323

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any of the information is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained by your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH e. COUNTY Wicomico b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Allen c. LENGTH OF STAY IN lb 8 Hrs. d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Wicomico Yacht Club		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Salisbury d. STREET ADDRESS Rt. # 50 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First NATHANIEL Middle JAMES Last ELLIOTT		4. DATE OF DEATH Month 6 Day 1 Year 1967	
5. SEX Male 6. COLOR OR RACE White 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 12-24-1910 9. AGE (In years last birthday) 56 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Short Order Cook 10b. KIND OF BUSINESS OR INDUSTRY Yacht Club 11. BIRTHPLACE (State or foreign country) Delaware-Sussex 12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Thomas Elliott 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) No 16. SOCIAL SECURITY NO. 186-05-3727 17. INFORMANT Mrs. Edna I. Elliott, see sec.2 Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) total B... 916.6 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH minutes	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH. Trailor Fire 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour 5:30 e.m. p.m. Month, Day, Year 6-1-67 20d. INJURY OCCURRED While <input checked="" type="checkbox"/> Not While <input type="checkbox"/> et work et work 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home 20f. (City or town) Salisbury (County) Wicomico (State) MD			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE Earl L. Royer EXAMINER'S NAME (Type) Dr. Earl L. Royer M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED 6-2-67	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial 22b. DATE THEREOF 6-3-1967 22c. NAME OF CEMETERY OR CREMATORY Wicomico Memorial Park 22d. LOCATION (City, town, or country) Salisbury, Maryland (State)			
23. FUNERAL DIRECTOR Hill Funeral Home, Salisbury, Maryland ADDRESS		24a. REC'D BY REGISTRAR JUN 5 1967 24b. REGISTRAR'S SIGNATURE Charles Judge	

SEDIMENTARY

08825

CERTIFICATE OF DEATH

08823

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Worcester</u> ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Snow Hill</u> 23.0	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Peninsula General Hospital</u>		d. STREET ADDRESS <u>115 B Gunby St.</u>	
3. NAME OF DECEASED (Type or print) <u>Tessie</u> First <u>9.</u> Middle <u>EVARETT</u> Last		4. DATE OF DEATH <u>June 19</u> Month <u>19</u> Day <u>67</u> Year	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>NEGRO</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 10 1910</u> 56 yrs.
9. AGE (In years last birthday)		10. BIRTHPLACE (County & State, or foreign country) <u>Florida</u>	
11. BIRTHPLACE (County & State, or foreign country)		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Roscoe Everett</u>		14. MOTHER'S MAIDEN NAME <u>Jane Clemons</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>253 52 2376</u>	
17. INFORMANT <u>Mrs. Jesse B. Everett</u>		Address <u>Snow Hill Md.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchogenic Carcinoma C</u> 1621 DUE TO <u>Generalized Metastases</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Not Known</u> (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>5/8/67</u> to <u>6/11/67</u> that (I) (we) last saw the deceased alive on <u>6/11/67</u> and that death occurred at <u>6:45 p.m.</u> from causes and on the date stated above.			
22a. SIGNATURE <u>[Signature]</u>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>[Signature]</u>		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>June 21, 1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Mt. Zion Baptist</u>	23d. LOCATION (City or Town) (County) (State) <u>Snow H. Md. Maryland</u>
24. FUNERAL DIRECTOR <u>Thomas F. Fleming</u>		25a. REC'D BY REGISTRAR <u>JAN 22 1967</u>	25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in only event, within 72 hours after death.

STATE OF TEXAS COUNTY OF DALLAS

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

08826

CERTIFICATE OF DEATH

08824

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury	
c. LENGTH OF STAY IN 1b 4 Days		d. STREET ADDRESS 405 Naylor St.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Deer's Head State Hospital, Salisbury, Md.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) DELIA MAE (COLLINS) Feddern		4. DATE OF DEATH Month June Day 11 Year 19 67	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 15, 1890
9. AGE (In years lost birthday) 77 yrs.		10. IF UNDER 1 YEAR Months 2 Days 26 Hours Min. 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Owner & Operator		10b. KIND OF BUSINESS OR INDUSTRY Apartment House	
11. BIRTHPLACE (County & State, or foreign country) Gumboro, Delaware		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Noah James Collins		14. MOTHER'S MAIDEN NAME Sarah Margaret Bowden	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 	
17. INFORMANT Mrs. Hazel T. Kellam (Niece) 625 Truitt St., Salisbury, Maryland		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bilateral bronchopneumonia 332X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Cerebral thrombosis DUE TO (c) Arteriosclerosis		INTERVAL BETWEEN ONSET AND DEATH 2 days 1 months Years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) N/A		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) N/A	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 		20f. (City or town) (County) (State) 	
21. I certify that (I) (this hospital) attended the deceased from 6/7 , 1967 to 6/11 , 1967, that (I) (we) last saw the deceased alive on 6/11 , 1967, and that death occurred at 7:30 P.M. from causes and on the date stated above.			
22a. SIGNATURE L. V. Maldve		22b. DATE SIGNED 6/12/67	
22c. PHYSICIAN'S NAME (Type) L. V. Maldve, M. D.		22d. ADDRESS Deer's Head State Hospital, Salisbury, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF June 14, 1967	
23c. NAME OF CEMETERY OR CREMATORY Millsboro Cemetery Inc.		23d. LOCATION (City or Town) (County) (State) Millsboro, Delaware	
24. FUNERAL DIRECTOR HOLLOWAY & COMPANY, SALISBURY, MARYLAND		25. RECEIVED BY REGISTRAR JUN 14 1967	
26. REGISTRAR'S SIGNATURE Charles Judge		27. REGISTRAR'S SIGNATURE 	

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DEPARTMENT OF DEFENSE

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

08827

CERTIFICATE OF DEATH

08825

1. PLACE OF DEATH o. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Dorchester</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury, Maryland</u>		c. LENGTH OF STAY IN 1b <u>40 days</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Deer's Head State Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>JOHN First MILBOURNE Middle Lost FLETCHER</u>		4. DATE OF DEATH Month <u>6</u> Day <u>4</u> Year <u>1967</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Colored</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 25, 1901</u>
9. AGE (In years lost birthday) <u>65</u> yrs.		10. IF UNDER 1 YEAR Months <u>6</u> Days <u>4</u> Hours <u>1</u> Min. <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Day Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farming</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Dorchester Co., Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Levin L. Fletcher</u>		14. MOTHER'S MAIDEN NAME <u>Henrietta Johnson</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>	
17. INFORMANT <u>Luther L. Fletcher, Hurlock, Maryland, RFD</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma Rectum w/Metastases to Perineum & sacrum</u> <u>154X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>3-4 yrs.</u> (c) <u>3-4 yrs.</u>		INTERVAL BETWEEN ONSET AND DEATH <u>3-4 yrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u>19</u> a.m. p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>April 25, 1967</u> , to <u>June 4, 1967</u> , that (I) (we) last saw the deceased alive on <u>June 4, 1967</u> , and that death occurred at <u>12:15 A.M.</u> from causes and on the date stated above.			
22a. SIGNATURE <u>Chas. H. Winnacott</u> M.D.		22b. DATE SIGNED <u>6/5/67</u> Md.	
22c. PHYSICIAN'S NAME (Type) <u>Chas. H. Winnacott, M. D.</u>		22d. ADDRESS <u>Deer's Head State Hospital, Salisbury,</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>June 7, 1967</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Washington Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Hurlock, Maryland, RFD</u>	
24. FUNERAL DIRECTOR <u>J. J. Frampton and Son, Federalsburg, Maryland</u>		25a. REC'D BY REGISTRAR DATE <u>JUN 9 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>		25c. REGISTRAR'S NAME <u>[Signature]</u>	

8836

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the ~~decedent's~~ certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

08828

CERTIFICATE OF DEATH

08828

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Va.</u> b. COUNTY <u>Accomack</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Peninsula General Hospital</u>		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) <u>Baby Girl</u>		4. DATE OF DEATH <u>June 6, 1967</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 6, 1967</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Infant</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Md.</u>	
13. FATHER'S NAME <u>Russell Dennis</u>		14. MOTHER'S MAIDEN NAME <u>Pauline Harris</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Immaturity - 335 gm</u> DUE TO (b) <u>776X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>2 hr 45 min</u>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>6/6, 1967</u> to <u>6/6, 1967</u> , that (I) (we) last saw the deceased alive on <u>6/6, 1967</u> , and that death occurred at <u>9:45</u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>DS Oulerson</u>		22b. DATE SIGNED <u>6/6/67</u>	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF <u>6-7-67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Messongo Cem.</u>	23d. LOCATION (City or Town) (County) (State) <u>Messongo Accomack Va.</u>
24. FUNERAL DIRECTOR <u>Laurie Sawyer</u>		25. FILED BY REGISTRAR <u>JUN 9 1967</u>	
26. ADDRESS <u>New Church</u>		27. REGISTRAR'S SIGNATURE <u>Judge</u>	

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UNITED STATES OF AMERICA

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

08823

CERTIFICATE OF DEATH

08827

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Va.</u> b. COUNTY <u>Accomack</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. LENGTH OF STAY IN 1b <u>83.3</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Peninsula General Hospital</u>		d. STREET ADDRESS <u>Makemie Park</u>	
3. NAME OF DECEASED (Type or print) <u>Baby Girl</u>		4. DATE OF DEATH Month <u>June</u> Day <u>6</u> Year <u>1967</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 6, 1967</u>
9. AGE (In years lost birthday) <u>2</u> yrs.		10. IF UNDER 1 YEAR Months <u>2</u> Days <u>15</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Infant</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Infant</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Russell Dennis</u>		14. MOTHER'S MAIDEN NAME <u>Pauline Harris</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Address</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <u>776X</u> IMMEDIATE CAUSE (a) <u>Immaturity</u> DUE TO (b) <u>3359m</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>2 hr. 15"</u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>6/6</u> , 19 <u>67</u> , to <u>6/6</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>6/6</u> , 19 <u>67</u> , and that death occurred at <u>7:18</u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>DS Cullen</u>		22b. DATE SIGNED <u>6/6/67</u>	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>6-7-67</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Messongo Cem.</u>		23d. LOCATION (City or Town) (County) (State) <u>Messongo Accomack Va.</u>	
24. FUNERAL DIRECTOR <u>Samuel South New Church, Va.</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		DATE <u>JUN 9 1967</u>	

INVESTIGATION

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

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MAY 1967

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08830

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

08828

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Wicomico b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury, Maryland c. LENGTH OF STAY in 1b 3mo. 3 days d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Deer's Head State Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Somerset c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crisfield d. STREET ADDRESS 190 Chesapeake Ave. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Lina Middle W. Last Hastings		4. DATE OF DEATH Month June Day 10 Year 19 67	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 30, 1879
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY None	9. AGE (In years last birthday) 87 IF UNDER 1 YEAR: Months 19 Days 2 IF UNDER 24 HRS.: Hours 19 Min. 2
11. BIRTHPLACE (County & State, or foreign country) Accomack Co., Va.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME James Archer		14. MOTHER'S MAIDEN NAME Mahalia (?)	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 220-03-0046	
17. INFORMANT Albert L. Watson		Address Crisfield, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bilateral bronchopneumonia Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. 491X (b) Carcinoma of breast, left DUE TO (c) 491X		INTERVAL BETWEEN ONSET AND DEATH 3 days 6 months	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. 19 p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from March 7, 19 67 , to June 10, 19 67 , that (I) (we) last saw the deceased alive on June 10, 19 67 , and that death occurred at 10:15 PM from causes and on the date stated above.			
22a. SIGNATURE L. Maldve		22b. DATE SIGNED June 11, 1967	
22c. PHYSICIAN'S NAME (Type) L. Maldve, M.D.		22d. ADDRESS Salisbury, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF June 13, 1967	23c. NAME OF CEMETERY OR CREMATORY Sunnyridge Cemetery	23d. LOCATION (City or Town) (County) (State) Crisfield, Md.
24. FUNERAL DIRECTOR Bradshaw & Sons, Crisfield, Md.		25a. REC'D BY REGISTRAR JUN 16 1967	
25b. REGISTRAR'S SIGNATURE J. Charles Judge			

OFFICIALS IN DEATH

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Mr. J. Edgar Hoover

U. S. Department of Justice

Dear Sir:

Reference is made to your letter of April 1, 1964.

Enclosed for you are two copies of a letterhead memorandum.

Very truly yours,

W. J. Rorick, Director

W. J. Rorick, Director

W. J. Rorick, Director

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death.
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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
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MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

08831

CERTIFICATE OF DEATH

08829

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE DELTWARE b. COUNTY SUSSEX	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SELBYVILLE	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Peninsula General Hospital		d. STREET ADDRESS RD (FENWICK Is.)	
3. NAME OF DECEASED (Type or print) TASKER, TIMOTHY HUDSON		4. DATE OF DEATH Month JUNE Day 17 Year 1967	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12-27-1895
9. AGE (In years last birthday) 71 yrs.		10. IF UNDER 1 YEAR Months 17 Days 17 Hours 17 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED MARINE ENG.		10b. KIND OF BUSINESS OR INDUSTRY —	
11. BIRTHPLACE (County & State, or foreign country) DELAWARE		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME JAMES TIMOTHY HUDSON		14. MOTHER'S MAIDEN NAME CHARLOTTE HUDSON	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO. 180-12-9999	
17. INFORMANT EDITH B. HUDSON		Address SELBYVILLE, DE	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Interiosclerotic Heart Disease DUE TO (b) 4300 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) — DUE TO (c) —		INTERVAL BETWEEN ONSET AND DEATH 1 yr	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) Pulmonary Emphysema		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from June 11, 1967 to June 17, 1967 that (I) (we) last saw the deceased alive on June 16, 1967 and that death occurred at 3:45 PM from causes and on the date stated above.			
22a. SIGNATURE Sam J. Gilmore		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 6-21-67	
23c. NAME OF CEMETERY OR CREMATORY ODDFELLOWS Cem.		23d. LOCATION (City or Town) (County) (State) BISHOPVILLE, MD	
24. FUNERAL DIRECTOR A. Douglas Melton, Frankford Del.		25a. REC'D BY REGISTRAR Charles Judge	
25b. REGISTRAR'S SIGNATURE Charles Judge		DATE JUN 27 1967	

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

08832

Item #1b & d Film #C390 7/5/67 ps

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08830

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Wicomico</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Upper Ferry</u>				c. LENGTH OF STAY IN lb		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Eden Maryland 22-1</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Rural 6 miles west of Salisbury, Md.</u>				d. STREET ADDRESS <u>Rt 2 Box 54</u>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Cecil</u> Middle <u>Ronald</u> Last <u>JACKSON</u>				4. DATE OF DEATH Month <u>6</u> Day <u>15</u> Year <u>1967</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MARCH 28-54</u>		9. AGE (In years last birthday) <u>15</u> yrs.	IF UNDER 1 YEAR Months <u>15</u> Days <u>15</u> Hours <u>15</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Wicomico</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Spotwood Jackson</u>				14. MOTHER'S MAIDEN NAME <u>Emogene Polk</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Emogene Jackson</u> Address <u>Rt 2 Box 54 Eden Maryland</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 9298 IMMEDIATE CAUSE (a) <u>Drowning</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>DUE TO</u> (c) <u>DUE TO</u>							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Drowned while swimming</u>					
20c. TIME OF INJURY Hour <u>4:30</u> AM <input type="checkbox"/> PM <input checked="" type="checkbox"/> Month, Day, Year <u>6-15-67</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Wicomico River</u>		20f. (City or town) (County) (State) <u>Upper Ferry Wic. Md.</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Philip A. Insley</u>		EXAMINER'S NAME (Type) <u>Ph. A. Insley</u>		M.D.		22. DATE SIGNED <u>6-20-67</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>6-18-67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Green Methodist</u>		23d. LOCATION (City or Town) (County) (State) <u>Eden Wic. Md.</u>	
24. FUNERAL DIRECTOR <u>Harold E. Jones</u> ADDRESS <u>Salisbury, Md.</u>				25a. REC'D BY REGISTRAR DATE <u>JUN 20 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

0500

RECEIVED 11-11-61

0500

08833

CERTIFICATE OF DEATH

08832

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Somerset			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Princess Anne 19-2			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Peninsula General Hospital				d. STREET ADDRESS P.O. Box 383		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Noland Purrell James				4. DATE OF DEATH Month Day Year June 15 1967			
5. SEX MALE	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4/23/1899	9. AGE (In years lost birthday) yrs. 68	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Princess Anne Somerset Md		12. CITIZEN OF WHAT COUNTRY? U.S.A	
13. FATHER'S NAME Woodland P. James Sr.				14. MOTHER'S MAIDEN NAME Julia C. Logan			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 244-01-7841		17. INFORMANT Address Elsie Tilghman Princess Anne, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thrombosis DUE TO (b) Cerebral Arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Pneumonia							INTERVAL BETWEEN ONSET AND DEATH 1 day
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from May 8, 1967 to June 15, 1967 , that (I) (we) last saw the deceased alive on May 15, 1967 , and that death occurred at 4:45 PM from causes and on the date stated above.							
22a. SIGNATURE Shaw J. Gilmore				22b. DATE SIGNED		22c. PHYSICIAN'S NAME (Type)	
M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				22d. ADDRESS			
23a. BURIAL CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 6/19/67		23c. NAME OF CEMETERY OR CREMATORY John Wesley		23d. LOCATION (City or Town) (County) (State) Princess Anne Somerset, Md.	
24. FUNERAL DIRECTOR William H. James III 258 Church St. Princess Anne, Md.				25a. REC'D BY REGISTRAR JUN 23 1967		25b. REGISTRAR'S SIGNATURE J. Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

58300

STATE OF TEXAS

22330

THE STATE OF TEXAS, COUNTY OF DALLAS, ss. I, the undersigned, Clerk of the County, do hereby certify that the within and foregoing is a true and correct copy of the original as the same appears from the records of the County of Dallas, Texas.

08834

CERTIFICATE OF DEATH

08833

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Delaware b. COUNTY New Castle	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Wilmington	
c. LENGTH OF STAY in 1b Adm. in 1 D 6/2/67		d. STREET ADDRESS Edgemore Gardens 5 S. Penniwell Drive	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Peninsula General Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last FRANKLIN DAVID JARMAN		4. DATE OF DEATH Month Day Year June 3 1967	
5. SEX MALE	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH December 1, 1898
9. AGE (In years last birthday) 68 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Engineer		10b. KIND OF BUSINESS OR INDUSTRY Railroad	
11. BIRTHPLACE (County & State, or foreign country) Berlin, Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John E. Jarman		14. MOTHER'S MAIDEN NAME Nancy Elizabeth Coffin	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO.	
17. INFORMANT Mrs. Beulah M. Jarman (Wife) 5 S. Penniwell Dr., Wilmington, Delaware		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Coronary Artery Thrombosis 4201 DUE TO (b) 1 day Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) N/A	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from June 2, 1967 to June 3, 1967 , that (I) (we) last saw the deceased alive on June 2, 1967 , and that death occurred at 2:45 A.M. from causes and on the date stated above.			
22a. SIGNATURE David J. Gilmore		22b. DATE SIGNED June 3, 1967	
22c. PHYSICIAN'S NAME (Type) Dr. David J. Gilmore		22d. ADDRESS Medical Center, Salisbury, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF June 7, 1967	23c. NAME OF CEMETERY OR CREMATORY Gracelawn Cemetery	23d. LOCATION (City or Town) (County) (State) Wilmington, Delaware
24. FUNERAL DIRECTOR HOLLOWAY & COMPANY, SALISBURY, MARYLAND		25a. REC'D BY REGISTRAR DATE JUN 6 1967	
		25b. REGISTRAR'S SIGNATURE Charles Judge	

CERTIFICATE OF DEATH

22

<p>1. Name of deceased</p>		<p>2. Sex</p>	
<p>3. Age</p>		<p>4. Date of birth</p>	
<p>5. Place of birth</p>		<p>6. Date of death</p>	
<p>7. Cause of death</p>		<p>8. Place of death</p>	
<p>9. Signature of physician</p>		<p>10. Signature of registrar</p>	
<p>11. Date of registration</p>		<p>12. Place of registration</p>	

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

08835

CERTIFICATE OF DEATH

08834

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE Maryland b. COUNTY Wicomico	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hebron		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hebron 221	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Main St.,		d. STREET ADDRESS Main St.,	
3. NAME OF DECEASED (Type or print) First WILLIAM Middle THEODORE Last JENKINS		4. DATE OF DEATH Month 6 Day 8 Year 1967	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH Aug. 12, 1889
9. AGE (In years for birthday) yrs. 77		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Barber		10b. KIND OF BUSINESS OR INDUSTRY Own Shop	
11. BIRTHPLACE (County & State, or foreign country) Maryland, Wicomico		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Theodore Kibble Jenkins		14. MOTHER'S MAIDEN NAME Sarah Virginia Watson	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO. 218-34-9321	
17. INFORMANT Mrs. Grace Jenkins, sec 2		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4500 Arteriosclerosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			INTERVAL BETWEEN ONSET AND DEATH 10 yrs
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 4/7 , 19 67 , to 6/7 , 19 67 , that (I) (we) last saw the deceased alive on 6/7 , 19 67 , and that death occurred at 3:55 A.M. from causes and on the date stated above.			
22a. SIGNATURE S. Hurdle		22b. DATE SIGNED 6/9/67	
22c. PHYSICIAN'S NAME (Type) Dr. S.H. Hurdle		22d. ADDRESS Hebron, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 6-10-1967	23c. NAME OF CEMETERY OR CREMATORY Sp. Hill Memory Gardens	23d. LOCATION (City or Town) (County) (State) Hebron, Maryland
24. FUNERAL DIRECTOR Hill Funeral Home Salisbury, Maryland		25a. REC'D BY REGISTRAR June 14 1967	
		25b. REGISTRAR'S SIGNATURE Charles J. J...	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

CERTIFICATE OF SALE

00330

UNITED STATES DEPARTMENT OF AGRICULTURE
BUREAU OF LAND MANAGEMENT

Section 1. This certificate is issued to the holder of the following land grant or claim, to wit:

Section 2. The land is situated in the following township and range, to wit:

Section 3. The land is situated in the following county, to wit:

Section 4. The land is situated in the following state, to wit:

Section 5. The land is situated in the following section, to wit:

Section 6. The land is situated in the following quarter section, to wit:

Section 7. The land is situated in the following quarter section, to wit:

Section 8. The land is situated in the following quarter section, to wit:

Section 9. The land is situated in the following quarter section, to wit:

Section 10. The land is situated in the following quarter section, to wit:

Section 11. The land is situated in the following quarter section, to wit:

Section 12. The land is situated in the following quarter section, to wit:

Section 13. The land is situated in the following quarter section, to wit:

Section 14. The land is situated in the following quarter section, to wit:

Section 15. The land is situated in the following quarter section, to wit:

Section 16. The land is situated in the following quarter section, to wit:

Section 17. The land is situated in the following quarter section, to wit:

Section 18. The land is situated in the following quarter section, to wit:

Section 19. The land is situated in the following quarter section, to wit:

Section 20. The land is situated in the following quarter section, to wit:

Section 21. The land is situated in the following quarter section, to wit:

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

08836

CERTIFICATE OF DEATH

08835

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Peninsula General Hospital</u>		d. STREET ADDRESS <u>831 S. Division St.</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>IRVING THOMAS Johnson</u>		4. DATE OF DEATH Month Day Year <u>JUNE 26 1967</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 25, 1887</u>
9. AGE (In years lost birthday) <u>80</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min. <u>1 1 1</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Custodian</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Board of Education - Worcester Co., Md.</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>USA</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Irving Thomas Johnson</u>		14. MOTHER'S MAIDEN NAME <u>Mary Townsend</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>220-09-1622</u>	
17. INFORMANT <u>Mrs. Elizabeth Hearn</u> Address <u>831 S. Division St., Salisbury, Md.</u>			
18. CAUSE OF DEATH (Enter only one cause per line, for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Heart Failure</u> DUE TO (b) <u>H.A.S.C.U.D.</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Partial intestinal obstruction thrombophlebitis pulmonary infarct</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>N/A</u>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>June 26, 1967</u> , to <u>June 26, 1967</u> , that (I) (we) last saw the deceased alive on <u>June 26, 1967</u> , and that death occurred at <u>8:55 P.M.</u> from causes and on the date stated above.			
22a. SIGNATURE <u>Thomas P. Bigbee</u>		22b. DATE SIGNED <u>June 26, 1967</u>	
22c. PHYSICIAN'S NAME (Type) <u>Dr. Thomas P. Bigbee</u>		22d. ADDRESS <u>Maryland Ave., Salisbury, Maryland</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>June 29, 1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Pusey Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Worcester Co., Md.</u>
24. FUNERAL DIRECTOR <u>HOLLOWAY & COMPANY, SALISBURY, MD.</u>		25a. REC'D BY REGISTRAR DATE <u>JUN 28 1967</u>	25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>

36835

CERTIFICATE OF DEATH

08837

08836

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury			c. LENGTH OF STAY IN 1b			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Peninsula General Hospital				d. STREET ADDRESS 205 Brooklyn Ave.			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last MARION EDWARD JONES				4. DATE OF DEATH Month Day Year JUNE 10 1967			
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH May 9, 1902		9. AGE (In years last birthday) 65 yrs.	IF UNDER 1 YEAR Months Days Hours Min. 1 1	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mechanic		10b. KIND OF BUSINESS OR INDUSTRY Automobile		11. BIRTHPLACE (County & State, or foreign country) Delmar, Delaware		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Arthur Edward Jones				14. MOTHER'S MAIDEN NAME Martha Elizabeth Hastings			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 214-10-7249		17. INFORMANT Mrs. Edith M. Jones (Wife) 205 Brooklyn Ave., Salisbury, Maryland			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4201 Congestive Heart Failure DUE TO (b) Ischemic Heart Disease DUE TO (c) Coronary Arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							INTERVAL BETWEEN ONSET AND DEATH 1 year Not Known Not Known
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) N/A				
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office, etc.)		20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 6/5/1967 to 6/10/1967 that (I) (we) lost saw the deceased alive on 6/9/1967 , and that death occurred at 5:30 P.M. from causes on and on the date stated above.							
22a. SIGNATURE Dr. O. J. Burton				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED June 10, 1967	
22c. PHYSICIAN'S NAME (Type) Dr. O. J. Burton				22d. ADDRESS Medical Center, Salisbury, Maryland			
23a. BURIAL CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF June 12, 1967		23c. NAME OF CEMETERY OR CREMATORY Wicomico Memorial Park		23d. LOCATION (City or Town) (County) (State) Salisbury, Maryland	
24. FUNERAL DIRECTOR HOLLOWAY & COMPANY, SALISBURY, MARYLAND				25a. REC'D BY REGISTRAR JUN 14 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

35330

RECEIVED 10 10 1961

35330

TO: DIRECTOR, FBI
FROM: SAC, NEW YORK (100-100000)
SUBJECT: [Illegible]
[The remainder of the document contains several paragraphs of extremely faint, illegible text, likely a teletype or memorandum. The text is mirrored across the page, suggesting bleed-through from the reverse side.]

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health at its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE HEALTH DEPT.

08838

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08837

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury			c. LENGTH OF STAY IN 1b			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Peninsula General Hospital D.O.A.				d. STREET ADDRESS 907 E, Church St.			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last RALPH EMERSON LARMORE				4. DATE OF DEATH Month Day Year JUNE 25 19 67				
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH September 22, 1908		9. AGE (In years last birthday) yrs. 58	IF UNDER 1 YEAR Months Days Hours Min. 3		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Contract Painter		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Oxford, Maryland		12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME Elhue A. Larmore				14. MOTHER'S MAIDEN NAME Sarah J. Harrison				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 212-10-6766		17. INFORMANT Address Mrs. Geneva M. Larmore (Wife) 907 E. Church St., Salisbury, Maryland				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH sudden	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>								
ACTUAL SIGNATURE Earl L. Royer, M.D. EXAMINER'S NAME (Type) 409 Camden Ave., Salisbury, Md.		M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		22. DATE SIGNED June 26 / 1967		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF June 28, 1967		23c. NAME OF CEMETERY OR CREMATORY Wicomico Memorial Park		23d. LOCATION (City or Town) (County) (State) Salisbury, Maryland		
24. FUNERAL DIRECTOR ADDRESS HOLLOWAY & COMPANY, SALISBURY, MARYLAND				25a. BY REGISTRAR JUN 28 1967 DATE		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>		

[Handwritten signature]

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

08833

CERTIFICATE OF DEATH

08838

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. LENGTH OF STAY IN 1b <u>25 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Peninsula General Hospital</u>				d. STREET ADDRESS <u>715 Spring Avenue</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>EDNA</u> First <u>CHAUNCEY</u> Middle <u>LAYTON</u> Last				4. DATE OF DEATH Month <u>June</u> Day <u>5</u> Year <u>1967</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>April 10, 1890</u>	
9. AGE (In years last birthday) <u>77</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>		IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housework</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Union City, New Jersey</u>	
13. FATHER'S NAME <u>James J. Chauncey</u>				14. MOTHER'S MAIDEN NAME <u>Mary Ellen (maiden name unknown)</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give war or dates of service)				16. SOCIAL SECURITY NO. <u>218-34-9174-D</u>		17. INFORMANT Address <u>Mrs. David P. Mikelait, Salisbury, Md.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> DUE TO (b) <u>Hypertensive And Arteriosclerotic</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>Heart Disease</u>							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>MAY 10, 1967</u> to <u>June 5, 1967</u> , that (I) (was) last saw the deceased alive on <u>June 4, 1967</u> , and that death occurred at <u>8:00 AM</u> , from causes and on the date stated above.							
22a. SIGNATURE <u>Shawes C. Hill Jr.</u> M.D.				22b. DATE SIGNED <u>June 5, 1967</u>		22c. PHYSICIAN'S NAME (Type) <u>Pine Bluff Road, Salisbury, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>June 8, 1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Dorchester Memorial Park</u>		23d. LOCATION (City or Town) (County) (State) <u>Cambridge, Md., RFD</u>	
24. FUNERAL DIRECTOR <u>J. J. Frampton and Son, Federalburg, Maryland</u>				25a. REC'D BY REGISTRAR <u>JUN 6 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

2330

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

08840

08839

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u> c. LENGTH OF STAY in lb <u>Adm. in lb 6/10/67</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Peninsula General Hospital</u>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u> d. STREET ADDRESS <u>177 Ocean City Road</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>CHARLES HAROLD LITTLETON</u>		4. DATE OF DEATH Month Day Year <u>JUNE 28 1967</u>		5. SEX <u>Male</u>			
6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>March 28, 1901</u>			
9. AGE (In years last birthday) <u>66 yrs.</u>		IF UNDER 1 YEAR Months Days <u>3 0</u>		IF UNDER 24 HRS. Hours Min. <u>0 0</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired-Carpenter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Self-employed</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Wicomico County, Maryland</u>			
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>Charles Littleton</u>		14. MOTHER'S MAIDEN NAME <u>Band Morris</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>166-03-2812</u>		17. INFORMANT Address <u>Mrs. Mildred E. Littleton (Wife)</u> <u>177 Ocean City Road, Salisbury, Maryland</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>myocardial infarction</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. DUE TO (c) <u>4201</u>				INTERVAL BETWEEN ONSET AND DEATH <u>2 hrs.</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>N/A</u>					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 <u>67</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>N/A</u>			
20f. (City or town) <u>Salisbury</u>		(County) <u>Wicomico</u>					
21. I certify that (I) (this hospital) attended the deceased from <u>June 28, 1967</u> to <u>June 28, 1967</u> , that (I) (we) last saw the deceased alive on <u>June 28, 1967</u> , and that death occurred at <u>5:55 M.</u> from the causes and on the date stated above. 22a. SIGNATURE <u>Dr. E. M. Beardsley</u> 22c. PHYSICIAN'S NAME (Type) <u>Dr. E. M. Beardsley</u> 22b. DATE SIGNED <u>June 30, 1967</u> ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22d. ADDRESS <u>207 Maryland Avenue, Salisbury, Maryland</u>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>July 1, 1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Wicomico Memorial Park</u>			
23d. LOCATION (City, town or county) <u>Salisbury, Maryland</u>		(State) <u>Maryland</u>					
24. FUNERAL DIRECTOR'S SIGNATURE <u>HOLLOWAY & COMPANY, SALISBURY, MARYLAND</u>		25. REG. BY REGISTRAR DATE <u>JUL 5 1967</u> REGISTRAR'S SIGNATURE <u>[Signature]</u>					

CERTIFICATE OF DEATH

1. Name of deceased: **Charles E. Lippin**
2. Date of death: **Feb 28 1912**
3. Place of death: **177 Ocean City Road, Salisbury, Md.**
4. Cause of death: **Self-employed**
5. Age: **40**
6. Sex: **Male**
7. Race: **White**
8. Occupation: **Self-employed**
9. Marital status: **Married**
10. Name of spouse: **Elizabeth Lippin**
11. Name of informant: **Charles E. Lippin**
12. Signature of informant: *[Signature]*
13. Date of certificate: **Feb 28 1912**

Respectfully submitted

Feb 28 1912

Feb 28 1912

W. H. Lippin

507 Maryland Avenue, Salisbury, Md.
Salisbury, Md.
W. H. Lippin
Feb 28 1912

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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08841

CERTIFICATE OF DEATH

08840

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>VIRGINIA</u> b. COUNTY <u>ACCOMAC</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. LENGTH OF STAY IN TB		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CHINCOTEAGUE</u> 83.3			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Peninsula General Hospital</u>				d. STREET ADDRESS <u>Ridge Road</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>MINNIE Birch LUNN</u>				4. DATE OF DEATH Month Day Year <u>JUNE 4 1967</u>			
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9-30-79</u>	9. AGE (In years last birthday) yrs. <u>87</u>	10. IF UNDER 1 YEAR Months Days		11. IF UNDER 24 HRS. Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Self</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Wise Birch</u>				14. MOTHER'S MAIDEN NAME <u>Mariah Andrews</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>230-01-3945</u>		17. INFORMANT Address <u>Ora Harris, Bridgeville, Delaware</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Heart failure</u> DUE TO (b) <u>Pneumonia L.H.L.</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH <u>3 days?</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>ASCVD, osteoporosis, malnutrition</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a.m. Month, Day, Year p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>3 June</u> , 19 <u>67</u> , to <u>4 June</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>4 June</u> , 19 <u>67</u> , and that death occurred at <u>7:45</u> M, from causes and on the date stated above.							
22a. SIGNATURE <u>Joseph C. Fitzgerald</u>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>4 June 67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Joseph C. Fitzgerald</u>				22d. ADDRESS <u>Medical Center, Salisbury, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>June 7, 1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Thornton Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Chincoteague, Virginia</u>	
24. FUNERAL DIRECTOR <u>Salzer Funeral Home, Chincoteague, Virginia</u>				DATE <u>JUN 7 1967</u>			

54820

1202

222

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/66

08842

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08841

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pittsville	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Peninsula General Hospital		d. STREET ADDRESS In village	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First HARRY Middle ISAAC Last MIDDLETON		4. DATE OF DEATH Month JUNE Day 22 Year 19 67	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH October 16, 1892
9. AGE (In years lost birthday) yrs. 74		IF UNDER 1 YEAR Months 8 Days 6 Hours Min. 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Florist & Nurseryman		10b. KIND OF BUSINESS OR INDUSTRY 	
11. BIRTHPLACE (State or foreign country) Pittsville, Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME William Thomas Middleton		14. MOTHER'S MAIDEN NAME Mariah Hamblin	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 220-32-0150	
17. INFORMANT Miss Edna Middleton (Sister)		Address Pittsville, Maryland	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Fracture of Skull DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) 		INTERVAL BETWEEN ONSET AND DEATH Home	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) Driver of Auto Struck from behind	
20c. TIME OF INJURY Month, Day, Year 5:45 a.m. 6-22-1967		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office, bldg., etc.) 601st. Rd.		20f. (City or town) (County) (State) Pittsville Wic. Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Earl L. Royer, M. D.		22. DATE SIGNED June 23 / 1967	
EXAMINER'S NAME (Type) 409 Camden Ave., Salisbury, Md.		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF June 25, 1967	23c. NAME OF CEMETERY OR CREMATORY Pittsville Cemetery	23d. LOCATION (City or Town) (County) (State) Pittsville, Maryland
24. FUNERAL DIRECTOR HOLLOWAY & COMPANY, SALISBURY, MARYLAND		25a. REC'D BY REGISTRAR JUN 28 1967	
		25b. REGISTRAR'S SIGNATURE Charles Judge	

1333

29th

1333

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

08843

08842

1. PLACE OF DEATH				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)			
a. COUNTY Wicomico		b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Salisbury		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Salisbury		d. STREET ADDRESS 174 Ocean City Road	
e. STATE MARYLAND		f. COUNTY Wicomico		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) P.O. Address: 174 Ocean City Rd.							
3. NAME OF DECEASED (Type or print)				4. DATE OF DEATH			
First Middle Last HARVEY EDWIN NELSON				Month Day Year JUNE 25 1967			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH March 28, 1894	
9. AGE (In years last birthday) 73 yrs.		10. IF UNDER 1 YEAR Months Days 2 27		11. IF UNDER 24 HRS. Hours Min. 2 27			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Auditor-self employed				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Crisfield, Maryland	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME Lemuel Travis Nelson				14. MOTHER'S MAIDEN NAME Josephine Foreman			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) Yes War I				16. SOCIAL SECURITY NO. 214-10-6177		17. INFORMANT Address Mrs. Elva M. Nelson (Wife) 174 Ocean City Rd., Salisbury, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) cerebral vascular accident (thrombotic) 331X DUE TO Recurrent Basilar artery Syndrome (b) DUE TO generalized arteriosclerosis (c) 2 years ago PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 2 years ago							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) N/A							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) N/A		20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		20g. (County)		20h. (State)			
21. I certify that (I) (this hospital) attended the deceased from 1964 to June 25, 1967 , that (I) (we) last saw the deceased alive on June 22, 1967 , and that death occurred at 7:45 p.m. from the causes and on the date stated above.							
22a. SIGNATURE 				22b. DATE SIGNED June 27, 1967			
22c. PHYSICIAN'S NAME (Type) Dr. Robert T. Adkins				22d. ADDRESS Fruitland, Maryland			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF June 29, 1967		23c. NAME OF CEMETERY OR CREMATORY Crisfield Cemetery		23d. LOCATION (City, town or county) (State) Crisfield, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY, SALISBURY, MARYLAND				25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE Charles Judge	
25c. DATE JUN 29 1967							

Journal of Interpersonal Violence 27(12)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

08844

CERTIFICATE OF DEATH

08843

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. LENGTH OF STAY IN 1b <u>1 Day</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Delmar</u>		d. STREET ADDRESS <u>R.F.D. 3</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Peninsula General Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>VICTOR Adolph NELSON</u>		4. DATE OF DEATH Month <u>JUNE</u> Day <u>29</u> Year <u>1967</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3-25-1885</u>
9. AGE (In years last birthday) <u>82</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Preacher</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>New York, N.Y.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Frank Nelson</u>		14. MOTHER'S MAIDEN NAME <u>Ida Johnson</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>217-54-6154</u>	
17. INFORMANT <u>Mrs. Lydia Radecke, M. rdel, Md.</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of the eye</u> 192X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u> </u> DUE TO (c) <u> </u>		INTERVAL BETWEEN ONSET AND DEATH <u>unknown</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>6-28</u> , 19 <u>67</u> , to <u>6-29</u> , 19 <u>67</u> , that (I) (we) lost saw the deceased alive on <u>6-29</u> , 19 <u>67</u> , and that death occurred at <u>8:00</u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>Wilber R. Ellis, Jr.</u>		22b. DATE SIGNED <u>6-29-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>WILBER R. ELLIS, JR.</u>		22d. ADDRESS <u>MEDICAL CTR., SALISBURY, MD.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>7-1-1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Mardela Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>M. rdel, Maryland</u>
24. FUNERAL DIRECTOR <u>Hill Funeral Home Salisbury, Maryland</u>		25a. REC'D BY REGISTRAR <u>DALE JUL 3 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MARYLAND STATE DEPARTMENT OF HEALTH

08845

CERTIFICATE OF DEATH

08844

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Worcester ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. LENGTH OF STAY IN 1b 23-2	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Peninsula General Hospital		d. STREET ADDRESS 1208 Baltimore Ave.	
3. NAME OF DECEASED (Type or print) E. NORDQUIST First Middle Last		4. DATE OF DEATH June 8 1967 Month Day Year	
5. SEX male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 9, 1908
9. AGE (In years lost birthday) 58 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Proprietor		10b. KIND OF BUSINESS OR INDUSTRY Gasoline Station	
11. BIRTHPLACE (County & State, or foreign country) Sweden		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME ? Nordquist		14. MOTHER'S MAIDEN NAME Augusta ?	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 221-22-0526	
17. INFORMANT Mrs. Edna T. Nordquist (Same as 2 above)		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Septicemia DUE TO (b) Multiple Decubitus Ulcers DUE TO (c) Severe Rheumatoid Arthritis		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Malnutrition and Emaciation		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) lost saw the deceased alive on _____, 19____, and that death occurred at 6:30 AM, from causes and on the date stated above.			
22a. SIGNATURE David J. Gilmore		22b. DATE SIGNED 6-8-1967	
22c. PHYSICIAN'S NAME (Type) DAVID J. GILMORE		22d. ADDRESS SALISBURY, MD.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF June 10, 1967	23c. NAME OF CEMETERY OR CREMATORY Gracelawn Memorial Park	23d. LOCATION (City or Town) (County) (State) New Castle County, Del.
24. FUNERAL DIRECTOR Hill Funeral Home		25a. REC'D BY REGISTRAR JUN 12 1967	
ADDRESS SALISBURY, MD.		25b. REGISTRAR'S SIGNATURE Charles Judge	

MEDICAL CERTIFICATION

05333

CERTIFICATE OF DEATH

05333

Married

Married

John

1008 Baiting Ave.

58

11. 3. 1901

Swedish

Residing at

Residing at

August

August

551-55-1000 The T. H. Jones (See 55-1000)

1008 Baiting Ave. 11. 3. 1901 Swedish Residing at Residing at August August

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

08846

Item #8 Film #1390 6/26/67 pc

08845

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>Wicomico</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>	
c. LENGTH OF STAY IN b. <u>27 yrs</u>		d. STREET ADDRESS <u>221</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Maxine Road</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Lucy</u> Middle <u>O'Brian</u> Last <u>O'Brian</u>		4. DATE OF DEATH Month <u>6</u> Day <u>17</u> Year <u>1967</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6/11/1895</u>
9. AGE (In years last birthday) <u>71</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Wicomico MD.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>George Harrington</u>		14. MOTHER'S MAIDEN NAME <u>Telettha Dunn</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>217-03-9055</u>	
17. INFORMANT <u>Elva Phippin, Salisbury, MD.</u>		Address <u>Salisbury, MD.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial infarction</u> DUE TO (b) <u>4201</u> Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. (c) <u> </u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 hrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u> </u>	
20c. TIME OF INJURY Hour <u> </u> e.m. <u> </u> p.m. <u> </u> Month, Day, Year <u>6/19/67</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>	20f. (City or town) <u> </u> (County) <u> </u> (State) <u> </u>
21. I certify that (I) (this hospital) attended the deceased from <u>6/16/67</u> to <u>6/17/67</u> , that (I) (we) last saw the deceased alive on <u>6/16/67</u> , and that death occurred at <u>3A</u> M., from the causes and on the date stated above.			
22a. SIGNATURE <u>Earl Beardsley</u>		22b. DATE SIGNED <u>6/19/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Earl Beardsley</u>		22d. ADDRESS <u>Salisbury, Maryland</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>6/20/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Bivalve Cem.</u>	23d. LOCATION (City, town or county) <u>Bivalve, MD</u> (State) <u> </u>
24. FUNERAL DIRECTOR'S SIGNATURE <u>Charles Judge</u>		25a. REC'D BY REGISTRAR <u> </u> 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	
ADDRESS <u>Salisbury, Bivalve, MD.</u>		DATE <u>JUN 21 1967</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

08840

THE OFFICE OF THE

January 1945

Marine Corps

Office of the

Chief of Staff

Assistant

Chief of Staff

Major General

Colonel

Major General

Major General

Major General

Major General

Major General

Major General

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Item #7 Film #G389 8/19/67 dx

08847

CERTIFICATE OF DEATH

08846

1. PLACE OF DEATH o. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE Maryland b. COUNTY Wicomico	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Delmar	
c. LENGTH OF STAY IN 1b 217 days		d. STREET ADDRESS 308 Elizabeth Street	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Deer's Head State Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First EDITH Middle M. Last O'NEAL		4. DATE OF DEATH Month 6 Day 12 Year 1967	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug 8, 1892
9. AGE (In years lost birthday) yrs. 74		10. IF UNDER 1 YEAR Months 7 Days 12 Hours 19 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY home	
11. BIRTHPLACE (County & State, or foreign country) Delaware		12. CITIZEN OF WHAT COUNTRY? us	
13. FATHER'S NAME George Hosling		14. MOTHER'S MAIDEN NAME Ella Jenkins	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO. 22-05-9835	
17. INFORMANT Mr Carl Hill Laurel Del		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia, right 4200 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerotic heart disease DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 6 days Years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Intertrochanteric fracture, right		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from November 7, 1966 to June 12, 1967 , that (I) (we) last saw the deceased alive on June 12, 1967 , and that death occurred at 7:00 AM , from causes and on the date stated above.			
22a. SIGNATURE L. V. Maldve		22b. DATE SIGNED 6/12/67	
22c. PHYSICIAN'S NAME (Type) L. V. Maldve, M. D.		22d. ADDRESS Deer's Head State Hospital, Salisbury, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 6/14/67	23c. NAME OF CEMETERY OR CREMATORY St Stephens	23d. LOCATION (City or Town) (County) (State) Delmar Sussex Del
24. FUNERAL DIRECTOR Maxwell Ford Home		25a. REC'D BY REGISTRAR JUN 15 1967	
25b. REGISTRAR'S SIGNATURE Johnas J...			

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08888

STATEMENT OF WORK

STATEMENT OF WORK FOR THE PROJECT

Project Name: [illegible]

Project Manager: [illegible]

Project Start Date: [illegible]

Project End Date: [illegible]

Project Location: [illegible]

Project Description: [illegible]

Project Objectives: [illegible]

Project Deliverables: [illegible]

Project Risks: [illegible]

Project Budget: [illegible]

Project Resources: [illegible]

Project Status: [illegible]

Project History: [illegible]

Project Notes: [illegible]

Project Signatures: [illegible]

Project Date: [illegible]

Project Version: [illegible]

Project Page: [illegible]

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VR A15 (4)
20 M 1/66

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

08843

CERTIFICATE OF DEATH

08848

1. PLACE OF DEATH o. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>Somerset</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Princess Anne</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Peninsula General Hospital</u>		d. STREET ADDRESS <u>19-2</u>	
3. NAME OF DECEASED (Type or print) First <u>Louise</u> Middle <u>LYDIA</u> Last <u>PINKETT</u>		4. DATE OF DEATH Month <u>JUNE</u> Day <u>3</u> Year <u>1967</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>NEGRO</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3-9-21</u>
9. AGE (In years last birthday) yrs. <u>46</u>		IF UNDER 1 YEAR Months <u>46</u> Days <u>46</u> Hours <u>46</u> Min. <u>46</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Domestic</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>House work</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Charles Nutter</u>		14. MOTHER'S MAIDEN NAME <u>Annie Wallace</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>219-07-6332</u>	
17. INFORMANT <u>Roy Pinkett, Jr.</u>		Address <u>Princess Anne, Md.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Arrest</u> <u>4201</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Myocardial Infarction</u> DUE TO (c) <u>Arteriosclerotic Heart Disease</u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. <u>19</u> p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>May 27</u> , 19 <u>67</u> , to <u>June 3</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>June 3</u> , 19 <u>67</u> , and that death occurred at <u>12</u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>Thomas D. Hill, Jr.</u>		22b. DATE SIGNED <u>June 3, 1967</u>	
22c. PHYSICIAN'S NAME (Type) <u>Thomas D. Hill, Jr.</u>		22d. ADDRESS <u>Pine Bluff Road, Salisbury, Md</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>6-7-67</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>St Paul Cem.</u>		23d. LOCATION (City or town) (County) (State) <u>Princess Anne Somerset Md</u>	
24. FUNERAL DIRECTOR <u>Samuel L. Lavelle</u>		25a. REC'D BY REGISTRAR DATE <u>JUN 6 1967</u>	
ADDRESS <u>New Church, Va.</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

08850

CERTIFICATE OF DEATH

08849

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MD. b. COUNTY WICO.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SALISBURY 22-1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Peninsula General Hospital		d. STREET ADDRESS 425 W. COLLEGE AVE	
3. NAME OF DECEASED (Type or print) First ROBERT Middle HENRY Last POLLARD		4. DATE OF DEATH Month June Day 23 Year 1967	
5. SEX male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 6, 1894
9. AGE (In years last birthday) 72 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Plumbing		10b. KIND OF BUSINESS OR INDUSTRY Comm'l	
11. BIRTHPLACE (County & State, or foreign country) PENNA.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME ALBERT POLLARD		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 220-32-0089	
17. INFORMANT MRS. R.H. POLLARD		Address SEE #2	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction due to DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerotic Heart Disease DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (the doctor) attended the deceased from JUNE , 19 65 to JUNE 23 , 19 67 that (I) (we) last saw the deceased alive on JUNE 9 , 19 67 , and that death occurred at 4:30 P.M. from causes and on the date stated above.			
22a. SIGNATURE Thomas C. Hill Jr.		22b. DATE SIGNED June 23, 1967	
22c. PHYSICIAN'S NAME (Type) THOMAS C. HILL JR.		22d. ADDRESS Pine Bluff Road, Salisbury, Md	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF	
BURIAL		6/25/1967	
23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)	
MT. HOLLY CEM.		ONANCOCK, VA.	
24. FUNERAL DIRECTOR George C. Hill		25. REC'D BY REGISTRAR JUN 28 1967	
ADDRESS SALISBURY, MD.		25b. REGISTRAR'S SIGNATURE James Judge	

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UNITED STATES DEPARTMENT OF AGRICULTURE

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

08851

CERTIFICATE OF DEATH

08850

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. LENGTH OF STAY IN 1b 38 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Deer's Head State Hospital			d. STREET ADDRESS 404 Priscilla Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First PAUL Middle CRISFIELD Last POWELL			4. DATE OF DEATH Month 6 Day 16 Year 19 67		
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH December 23, 1876	9. AGE (In years lost birthday) 90 yrs.	IF UNDER 1 YEAR Months 5 Days 23 Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired-Custodian		10b. KIND OF BUSINESS OR INDUSTRY School		11. BIRTHPLACE (County & State, or foreign country) R.D., Powellville, Md.	
13. FATHER'S NAME Elisha Powell			14. MOTHER'S MAIDEN NAME Laura Burbage		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 220-32-2147		17. INFORMANT Address Mrs. Margaret P. Hearne (Daughter) 404 Priscilla Street, Salisbury, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Generalized Peritonitis 5721 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Ruptured Sigmoid Diverticuli DUE TO (c) 					INTERVAL BETWEEN ONSET AND DEATH 24 Hrs. 24 Hrs.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) N/A			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
21. I certify that (I) (this hospital) attended the deceased from May 9 , 19 67 , to June 16 , 19 67 , that (I) (we) last saw the deceased alive on June 16 , 19 67 , and that death occurred at 3:10 P.M. , from causes and on the date stated above.					
22a. SIGNATURE A. C. Mitchell			22b. DATE SIGNED 6/16/67		
22c. PHYSICIAN'S NAME (Type) Dr. A. C. Mitchell			22d. ADDRESS Deer's Head State Hospital, Salisbury,		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF June 18, 1967	23c. NAME OF CEMETERY OR CREMATORY Parsons Cemetery	23d. LOCATION (City or Town) (County) (State) Salisbury, Maryland		
24. FUNERAL DIRECTOR ADDRESS HOLLOWAY & COMPANY, SALISBURY, MARYLAND			25. REC'D BY REGISTRAR JUN 20 1967		25b. REGISTRAR'S SIGNATURE Charles Judge

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ALL INFORMATION CONTAINED HEREIN IS UNCLASSIFIED
DATE 08-01-2001 BY 60322 UCBAW/STW/KAS/STW

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1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 2674, 2675, 2676, 2677, 2678, 2679, 26

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

08852

CERTIFICATE OF DEATH

08851

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Cecil			
b. CITY OR TOWN (If outside corporate limits, write RURAL and nearest town) Salisbury			c. LENGTH OF STAY IN 1b 243 days	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rising Sun			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Deer's Head State Hospital				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Rissie Middle J. Last Ramey				4. DATE OF DEATH Month June Day 19 Year 19 67			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH Nov, 4, 1901		9. AGE (In years last birthday) 65 yrs.	IF UNDER 1 YEAR Months <input type="checkbox"/> Oays <input type="checkbox"/>	IF UNDER 24 HRS. Hours <input type="checkbox"/> Min. <input type="checkbox"/>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (County & State, or foreign country) Pike Co. Kentucky		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Isaac Justice				14. MOTHER'S MAIDEN NAME Rebecca Honaker			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. unknown		17. INFORMANT Address Mr. Jake Ramey Colora, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia DUE TO (b) Cerebral vascular accident; DUE TO (c) Hypertensive arteriosclerotic cardiovascular disease							INTERVAL BETWEEN ONSET AND DEATH 24 hours 1 year Years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 10/19 , 1966 , to 6/19 , 1967 , that (I) (we) last saw the deceased alive on June 19 , 19 67 , and that death occurred at 3:35 P.M. , from causes and on the date stated above.							
22a. SIGNATURE A. C. Mitchell, M.D.				ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED 6/19/67	
22c. PHYSICIAN'S NAME (Type) A. C. Mitchell, M. D.				22d. ADDRESS Deer's Head Hospital; Salisbury, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF June 22, 1967		23c. NAME OF CEMETERY OR CREMATORY Norman Cemetery		23d. LOCATION (City or Town) (County) (State) Pikeville Pike Ky.	
24. FUNERAL DIRECTOR W. H. Miller Div.				ADDRESS Rising Sun, Md.		25a. REC'D BY REGISTRAR JUN 22 1967	
				25b. REGISTRAR'S SIGNATURE J. Charles Judge			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

03322

STATE OF TEXAS

1932

County of ... State of Texas
I, the undersigned, Clerk of the County of ... State of Texas, do hereby certify that the within and foregoing is a true and correct copy of the ... as the same appears from the records of said County.

Witness my hand and the seal of said County at the City of ... this ... day of ... 1932.

Clerk of the County of ... State of Texas

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

08853

CERTIFICATE OF DEATH

08852

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Worcester</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Snow Hill</u> 232		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Peninsula General Hospital</u>				d. STREET ADDRESS <u>103 Franklin St.</u>			
3. NAME OF DECEASED (Type or print) First <u>Leland</u> Middle <u>B.</u> Last <u>Richardson</u>				4. DATE OF DEATH Month <u>June</u> Day <u>4</u> Year <u>1967</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 10 1885</u>	9. AGE (In years lost birthday) <u>81</u> yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	IF UNDER 24 HRS. Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Clerk-Manager</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Dispensary</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Snow Hill Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Thomas H. Richardson</u>				14. MOTHER'S MAIDEN NAME <u>Margaret Bowen</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>216 40 3982</u>		17. INFORMANT <u>Flossie H. Richardson, Snow Hill Md.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Amoxia</u> DUE TO (b) <u>chronic pulm. emphysema + bronchitis</u> DUE TO (c) <u>years.</u>							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Thrombosis & organization in Aorta, Thrombosis right main pulmonary artery</u>							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>5-11-67</u> , 19__, to <u>6-4-67</u> , 19__, that (I) (we) last saw the deceased alive on <u>6-4-67</u> 19__, and that death occurred at <u>11A</u> M, from causes and on the date stated above.							
22a. SIGNATURE <u>Joseph C. Fitzgerald</u>				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>6-4-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Joseph C. FITZGERALD</u>				22d. ADDRESS <u>Medical Center Salisbury Maryland</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>June 6, 1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Wheaton Methodist</u>		23d. LOCATION (City or Town) (County) (State) <u>Snow Hill Md.</u>	
24. FUNERAL DIRECTOR <u>Thomas F. Morris, Snow Hill Md.</u>				25a. REC'D BY REGISTRAR <u>JUN 7 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

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FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

08854

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08853

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Whitehaven				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				d. STREET ADDRESS			
3. NAME OF DECEASED (Type or print) First WARREN Middle EDGAR Last ROSS				4. DATE OF DEATH Month 6 Day 27 Year 67			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3-19-1890		9. AGE (In years lost birthday) yrs. 77	10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED CARPENTER				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) ORIOLE, MD.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.				13. FATHER'S NAME ROBERT J. ROSS			
14. MOTHER'S MAIDEN NAME REBECCA DAVIS				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)			
16. SOCIAL SECURITY NO.				17. INFORMANT Address MRS ALVA E. ROSS WHITE HAVEN, MD.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4201 Coronary Occlusion DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
21c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				21d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		21e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
21f. (City or town) (County) (State)				21g. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE Earl L. Royer, M.D. EXAMINER'S NAME (Type) 409 Camden Ave., Salisbury, Md.				22. DATE SIGNED June 27, 1967			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL				23b. DATE THEREOF 6/28/1967		23c. NAME OF CEMETERY OR CREMATORY ORIOLE, MARYLAND	
24. FUNERAL DIRECTOR ADDRESS Wilson Funeral Home, Princess Anne, Md.				25a. REC'D BY REGISTRAR DATE JUN 30 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	

6-1-60

1333

UNITED STATES DEPARTMENT OF STATE

OFFICE OF THE ASSISTANT SECRETARY FOR PUBLIC AFFAIRS

WASHINGTON, D.C. 20520

TELEPHONE 205-2000

TELETYPE 205-2000

MAIL ROOM 205-2000

RECORDS SECTION 205-2000

GENERAL INVESTIGATIVE DIVISION

UNITED STATES DEPARTMENT OF JUSTICE

WASHINGTON, D.C. 20535

TELEPHONE 205-2000

TELETYPE 205-2000

MAIL ROOM 205-2000

RECORDS SECTION 205-2000

GENERAL INVESTIGATIVE DIVISION

UNITED STATES DEPARTMENT OF JUSTICE

WASHINGTON, D.C. 20535

TELEPHONE 205-2000

TELETYPE 205-2000

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

08854

08855

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury				c. LENGTH OF STAY IN TB			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Willards				d. STREET ADDRESS xx			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Peninsula General Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) William E. Routzahn				4. DATE OF DEATH Month June Day 4 Year 1967			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH May 9, 1887	
9. AGE (In years last birthday) 80 yrs.		10. IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min.		11. IF UNDER 24 HRS. Months 0 Days 0 Hours 0 Min.		12. CITIZEN OF WHAT COUNTRY? USA	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer				10b. KIND OF BUSINESS OR INDUSTRY Lumber Mill		11. BIRTHPLACE (County & State, or foreign country) Maryland	
13. FATHER'S NAME Unknown				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes World # 1				16. SOCIAL SECURITY NO. 220-32-0692		17. INFORMANT Stella Mae Routzahn Willards, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive Heart Failure DUE TO (b) Hypertensive Heart Disease DUE TO (c) Abnormal							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from 5/14/1967 to 6/4/1967 that (I) (we) last saw the deceased alive on 6/4/1967 and that death occurred at 10:30 M, from causes and on the date stated above.							
22a. SIGNATURE [Signature]				22b. DATE SIGNED 6/4/1967			
22c. PHYSICIAN'S NAME (Type) [Signature]				22d. ADDRESS [Signature]			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF 6/7/67		23c. NAME OF CEMETERY OR CREMATORY Cooper		23d. LOCATION (City or Town) (County) (State) Willards, Md.	
24. FUNERAL DIRECTOR Edith Whaley Salisbury, Del.				25a. REC'D BY REGISTRAR DATE JUN 9 1967		25b. REGISTRAR'S SIGNATURE [Signature]	

STAY TO THE WAGER: STAY CALM

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

08856

CERTIFICATE OF DEATH

08855

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Worcester</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pocomoke City</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Peninsula General Hospital</u>				d. STREET ADDRESS <u>723 - 6th St.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>ISRAEL</u> Middle <u>SCHOOL FIELD</u> Last <u>SCHOOL FIELD</u>				4. DATE OF DEATH Month <u>JUNE</u> Day <u>9</u> Year <u>19 67</u>			
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov. 10, 1884</u>	9. AGE (In years (last birthday) yrs.) <u>82</u>	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Rail Road</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Samuel Schoolfield</u>				14. MOTHER'S MAIDEN NAME <u>Martha Gale</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Sarah Hughes</u> Address <u>Pocomoke City, Md.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive Heart Failure</u> DUE TO <u>Ischemic Heart Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Ischemic Heart Disease</u> (c) <u>Ischemic Heart Disease</u>						INTERVAL BETWEEN ONSET AND DEATH <u>approx 4 hrs</u> <u>Not known</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Pulmonary Infection - Pulmonary Emphysema</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>6/5/67</u> to <u>6/9/67</u> that (I) (we) last saw the deceased alive on <u>6/9/1967</u> and that death occurred at <u>11:52</u> M, from causes and on the date stated above.							
22a. SIGNATURE <u>[Signature]</u>				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>[Signature]</u>				22d. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>6-13-67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Unionville Cem.</u>		23d. LOCATION (City or Town) (County) (State) <u>Pocomoke Wbr. Md</u>	
24. FUNERAL DIRECTOR <u>Samuel Savage</u>				25a. REC'D BY REGISTRAR DATE <u>14 1967</u>		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

00228

RECORDS OF STATE

00228

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

08857

CERTIFICATE OF DEATH

10287

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>DELAWARE</u> b. COUNTY <u>SUSSEX</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. LENGTH OF STAY IN 1b <u>46.3</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>FRANKFORD</u>		d. STREET ADDRESS <u>RD</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Peninsula General Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>MINERVA</u> Middle <u>T.</u> Last <u>SCOTT</u>		4. DATE OF DEATH Month <u>JUNE</u> Day <u>21</u> Year <u>1967</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1-4-1910</u>
9. AGE (In years last birthday) <u>57</u> yrs.		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u> </u>	
11. BIRTHPLACE (County & State, or foreign country) <u>DELAWARE</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>WILMER TINGLE</u>		14. MOTHER'S MAIDEN NAME <u>MARY ELIZABETH TINGLE</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>221-24-7331</u>	
17. INFORMANT <u>CAROLYN NEWMAN, NEWARK, DEL.</u>		Address <u> </u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of the BREAST</u> DUE TO (b) <u>with Metastases</u> DUE TO (c) <u> </u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>170X</u>		INTERVAL BETWEEN ONSET AND DEATH <u> </u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u> </u>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>		20f. (City or town) (County) (State) <u> </u>	
21. I certify that (I) (this hospital) attended the deceased from <u>June 5</u> , 1967, to <u>June 21</u> , 1967, that (I) (we) last saw the deceased alive on <u>June 20</u> , 1967, and that death occurred at <u>6:07</u> A.M., from causes and on the date stated above.			
22a. SIGNATURE <u>Thomas C. Hill Jr.</u>		22b. DATE SIGNED <u>June 21, 1967</u>	
22c. PHYSICIAN'S NAME (Type) <u> </u>		22d. ADDRESS <u>PINE Bluff Road, Salisbury, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>6-25-67</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>ST. GEORGES CEMETERY</u>		23d. LOCATION (City or Town) (County) (State) <u>CLARKSVILLE, SUSSEX DEL.</u>	
24. FUNERAL DIRECTOR <u>G. Douglas Nelson, Frankford, Del.</u>		25a. REC'D BY REGISTRAR <u> </u>	
25b. REGISTRAR'S SIGNATURE <u>Charles J. ...</u>		DATE <u>JUL 11 1967</u>	

COMMITTEE OF DEATH

DECEASED

DECEASED

DECEASED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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2

91

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

08858

CERTIFICATE OF DEATH

08856

1. PLACE OF DEATH a. COUNTY WICOMICO MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Somerset			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury			c. LENGTH OF STAY IN 1b 58 Days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Princess Anne 19.2		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Deer's Head State Hospital, Salisbury, Md.				d. STREET ADDRESS Rt. #1, Box 252		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First William Middle Thurman Last Simpkins				4. DATE OF DEATH Month 6 Day 16 Year 19 67			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH FEB. 22, 1887		9. AGE (In years last birthday) 80 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED INSECTICIDE BUSINESS			10b. KIND OF BUSINESS OR INDUSTRY INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) MT. VERNON, MD.		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME GEORGE W. SIMPKINS				14. MOTHER'S MAIDEN NAME MARY ELIZABETH THOMAS			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO			16. SOCIAL SECURITY NO.		17. INFORMANT Address MRS MABLEL SIMPKINS PRINCESS ANNE MARYLAND		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia 4500 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Generalized arteriosclerosis. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) side'd paraly- Cerebral thrombosis with generalized arteriosclerosis & right / sis.							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from 4/19 , 19 67 to 6/16 , 19 67 that (I) (we) last saw the deceased alive on 6/16 , 19 67 , and that death occurred 10:30 M, from causes and on the date stated above.							
22a. SIGNATURE A. C. Mitchell				ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED 6/16/67	
22c. PHYSICIAN'S NAME (Type) A. C. Mitchell, M. D.				22d. ADDRESS Deer's Head State Hospital, Salisbury, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 6/18/1967		23c. NAME OF CEMETERY OR CREMATORY ASBURY CEMETERY		23d. LOCATION (City or Town) (County) (State) MT. VERNON, MD.	
24. FUNERAL DIRECTOR ADDRESS LEVIN R. WILSON PRINCESS ANNE, MD.				25a. REC'D BY REGISTRAR DATE JUN 19 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	

1828

Handwritten signature

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in on the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper (pages 1 and 2) and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 14
20 M 1/64

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

08853

CERTIFICATE OF DEATH

08857

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. LENGTH OF STAY IN lb <u>22-1</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Peninsula General Hospital</u>		d. STREET ADDRESS <u>Pocahontas Ave.</u>	
3. NAME OF DECEASED (Type or print) <u>UNDERWOOD</u> <u>WASHINGTON</u> <u>SMILEY</u>		4. DATE OF DEATH <u>JUNE 2</u> 19 <u>67</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>NEGRO</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 15, 1884</u>
9. AGE (In years lost birthday) <u>83</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Labor</u>	
10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>George Smiley</u>	
14. MOTHER'S MAIDEN NAME <u>Hattie ?</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>	
16. SOCIAL SECURITY NO.		17. INFORMANT <u>Venie Smiley Salisbury Md.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <u>163 X</u> IMMEDIATE CAUSE (a) <u>CARCINOMA OF Lung</u> DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH <u>4 weeks</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. _____ p.m. _____ 19 _____		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>5/28/67</u> , 19 <u>67</u> to <u>6/2</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>6/2</u> 19 <u>67</u> , and that death occurred at <u>10:05 AM</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>Robert J. Adkins</u>		22b. DATE SIGNED <u>2 June 67</u>	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>6/7/ 67</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Sharptown</u>		23d. LOCATION (City or Town) (County) (State) <u>Sharptown Md.</u>	
24. FUNERAL DIRECTOR <u>Clinton F. Stewart</u>		25a. REC'D BY REGISTRAR <u>Salie M.</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		DATE <u>JUN 6 1967</u>	

06830

CERTIFICATE OF DEATH

06830

FOR STATE
HEALTH DEPT

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death, if any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

08860

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08858

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Johnson's Lake		d. STREET ADDRESS Booth St.	
3. NAME OF DECEASED (Type or print) First ANTHONY Middle BOYD Last SMITH		4. DATE OF DEATH Month 6 Day 1 Year 1967	
5. SEX M	6. COLOR OR RACE AA	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 13, 1960
9. AGE (In years lost birthday) 7 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Allen Smith		14. MOTHER'S MAIDEN NAME Juanita Smith	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO.	
17. INFORMANT Allen Smith 417 Booth St. Salisbury, Md.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 9298 IMMEDIATE CAUSE (a) Drowning DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH minutes
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Found by father in 12 feet of water.	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 6-1-67 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work or work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Johnson's Lake		20f. (City or town) (County) (State) Salisbury, Wicomico, Md.	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Earl L. Royer, M.D. EXAMINER'S NAME (Type) 409 Camden Ave., Salisbury, Md.		22. DATE SIGNED June 8, 1967	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 6/4/1967	
23c. NAME OF CEMETERY OR CREMATORY Green Acres		23d. LOCATION (City or Town) (County) (State) Salisbury Md.	
24. FUNERAL DIRECTOR Clinton Stewart Clinton Stewart, Salisbury, Md.		25a. REGISTERAR'S SIGNATURE JUN 12 1967 DATE	

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JUN 1 1967

JUN 1 1967

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT.

VR A15ME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

08861

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08859

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. LENGTH OF STAY IN TB		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Wheatley's Labor Camp			d. STREET ADDRESS Wheatley's Labor Camp		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First JAMES Middle LEE Last SMITH			4. DATE OF DEATH Month 6 Day 4 Year 1967		
5. SEX M	6. COLOR OR RACE AA	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 21, 1946		9. AGE (In years lost birthday) 21 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Georgia	
13. FATHER'S NAME FLOYD SMITH			14. MOTHER'S MAIDEN NAME ELVA MAE USHER		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT FLOYD SMITH Jr. Address Allen MD	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bullet wound of heart 981X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) (c) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					INTERVAL BETWEEN ONSET AND DEATH minutes
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Shot by wife during altercation.			
20c. TIME OF INJURY Month, Day, Year Hour 11 p.m. 6-4-67		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input checked="" type="checkbox"/> at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Labor camp		20f. (City or town) (County) (State) Salisbury, Wicomico, Md.
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input checked="" type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE Earl L. Royer, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22. DATE SIGNED June 8, 1967	
EXAMINER'S NAME (Type) 109 Camden Ave., Salisbury, Md.		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		Address (Street, city, town, or county) Salisbury, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 6/4/67		23c. NAME OF CEMETERY OR CREMATORY Romfarns Beach	
24. FUNERAL DIRECTOR West Funeral Home, Salisbury, Md.		ADDRESS Salisbury, Md.		23d. LOCATION (City or town) (County) (State) Romfarns Beach Boardwalk	
25a. REC'D BY REGISTRAR June 12 1967		25b. REGISTRAR'S SIGNATURE Charles Judge		DATE June 12 1967	

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

08862

CERTIFICATE OF DEATH

08860

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Talbot	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. LENGTH OF STAY IN 1b 2 days	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cordova		20.2	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Pine Bluff State Hospital		d. STREET ADDRESS Box 94	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Viola Middle - Last Stanford		4. DATE OF DEATH Month June Day 3 Year 19 67	
5. SEX Female	6. COLOR OR RACE Colored	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 2, 1914
9. AGE (In years last birthday) 53 yrs.		IF UNDER 1 YEAR Months 3 Days 19 Hours 67 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY -	
11. BIRTHPLACE (County & State, or foreign country) Caroline Co., Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Milton Babes		14. MOTHER'S MAIDEN NAME Gertrude Young	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. unknown	
17. INFORMANT Records of Pine Bluff State Hospital		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Tuberculosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) 0021 (c) 0021		INTERVAL BETWEEN ONSET AND DEATH unknown	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Nat While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (s) (this hospital) attended the deceased from June 1, 1967 , to June 3, 1967 , that (s) (we) last saw the deceased alive on June 3, 1967 , and that death occurred at 9:15 PM , from causes and on the date stated above.			
22a. SIGNATURE E. P. Ritchings		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) E. P. Ritchings, M.D., Supt. Pine Bluff State Hospital		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 6-6-1967	
23c. NAME OF CEMETERY OR CREMATORY RICHARDSON		23d. LOCATION (City or Town) (County) (State) EASTON TALBOT MD	
24. FUNERAL DIRECTOR G. H. DASHIELL		25a. REC'D BY REGISTRAR Charles Judge	
25b. REGISTRAR'S SIGNATURE Charles Judge		DATE JUN 7 1967	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

08863

CERTIFICATE OF DEATH

08861

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY Wicomico		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. LENGTH OF STAY IN 1b Adm. in 1b 5/24/67	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Peninsula General Hospital			d. STREET ADDRESS 234 MAPLE WAY		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First WILLIAM Middle HENRY Last WARRINGTON			4. DATE OF DEATH Month JUNE Day 14 Year 1967		
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12-25-1900	9. AGE (In years last birthday) 66 yrs.	IF UNDER 1 YEAR Months 5 Days 19 Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired - Mechanic		10b. KIND OF BUSINESS OR INDUSTRY Automobile		11. BIRTHPLACE (County & State, or foreign country) Delaware	
13. FATHER'S NAME William H. Warrington			14. MOTHER'S MAIDEN NAME Annie Robinson		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 215-12-6624		17. INFORMANT Mrs. Lillian B. Warrington (Wife) P.O. Box 234, Mapleway, Salisbury, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) arteriosclerosis (heart disease) 4200 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) 					INTERVAL BETWEEN ONSET AND DEATH 2 weeks
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) N/A			
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. 	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from 5-24 , 19 67 to 6-14 , 19 67 that (I) (we) last saw the deceased alive on 6-14 , 19 67 , and that death occurred at 200 M, from causes and on the date stated above.					
22a. SIGNATURE Wilber R. Ellis, Jr.			22b. DATE SIGNED 6-14-67		
22c. PHYSICIAN'S NAME (Type) WILBER R. ELLIS, JR.			22d. ADDRESS Medical Center, Salisbury, Md.		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF June 17, 1967	23c. NAME OF CEMETERY OR CREMATORY Parsons Cemetery	23d. LOCATION (City or Town) (County) (State) Salisbury, Maryland		
24. FUNERAL DIRECTOR HOLLOWAY & COMPANY, SALISBURY, MARYLAND			25a. REC'D BY REGISTRAR 20 1967		25b. REGISTRAR'S SIGNATURE Charles Judge

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ALL INFORMATION CONTAINED HEREIN IS UNCLASSIFIED

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

08864

CERTIFICATE OF DEATH

08862

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Wicomico</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. LENGTH OF STAY IN 1b <u>Hrs.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Peninsula General Hospital</u>		d. STREET ADDRESS <u>509 N. Div. St.</u>	
3. NAME OF DECEASED (Type or print) First <u>Thomas</u> Middle <u>Edward</u> Last <u>Webb</u>		4. DATE OF DEATH Month <u>June</u> Day <u>2</u> Year <u>1967</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>DEC. 25, 1891</u>
9. AGE (In years last birthday) <u>75</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>BANKER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Comm L</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>SOMERSET, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Thomas J. Webb</u>		14. MOTHER'S MAIDEN NAME <u>Hettie Byrd</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <u>214-10-8680</u>	
17. INFORMANT <u>MRS. T.E. Webb -</u>		Address <u>SEE #2</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonitis and Aspiration</u> DUE TO (b) <u>Severe Pulmonary Emphysema</u> DUE TO (c) <u> </u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Severe Osteoarthritis AND Osteoporosis</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>June 2, 1967</u> to <u>June 2, 1967</u> , that (I) (we) last saw the deceased alive on <u>June 2, 1967</u> , and that death occurred at <u>3:30</u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>Thomas C. Hill Jr.</u>		22b. DATE SIGNED <u>June 2, 1967</u>	
22c. PHYSICIAN'S NAME (Type) <u>THOMAS C. HILL, JR. MD</u>		22d. ADDRESS <u>Pine Bluff Road, Salisbury Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>6/4/1967</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>SUNNYRIDGE CEM.</u>		23d. LOCATION (City or Town) (County) (State) <u>CRISFIELD, Som. Md.</u>	
24. FUNERAL DIRECTOR <u>George C. Hill Jr.</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u>	
ADDRESS <u>Salisbury, Md.</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	
DATE <u>JUN 5 1967</u>		DATE <u>JUN 5 1967</u>	

39380

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

08865

CERTIFICATE OF DEATH

08863

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Somerset</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Deal Island</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Deer's Head State Hospital</u>		d. STREET ADDRESS <u>--</u>	
3. NAME OF DECEASED (Type or print) First <u>ISADORA</u> Middle <u>E.</u> Last <u>WEBSTER</u>		4. DATE OF DEATH Month <u>6</u> Day <u>11</u> Year <u>1967</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6-17-1880</u>
9. AGE (In years last birthday) <u>86</u> yrs.		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEHOLD</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>HOUSEHOLD</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>JAMES DANIEL</u>		14. MOTHER'S MAIDEN NAME <u>MARY WILSON</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>UNKNOWN</u>	
17. INFORMANT <u>Leroy Webster Pruiett Anne Kid</u>		Address <u>2153</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchopneumonia</u> <u>H500</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerosis, generalized</u> DUE TO (c) <u> </u>			INTERVAL BETWEEN ONSET AND DEATH <u>1 week</u> <u>Years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u> </u> 19 <u>67</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>September 2, 1967</u> , to <u>June 11, 1967</u> , that (I) (we) last saw the deceased alive on <u>June 11, 1967</u> , and that death occurred at <u>10:10 PM</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>A. C. Mitchell</u>		22b. DATE SIGNED <u>6/12/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>A. C. Mitchell, M. D.</u>		22d. ADDRESS <u>Deer's Head State Hospital, Salisbury, Md.</u>	
23a. BURIAL, CREMATION, or REMOVAL (Specify) <u>BURIAL</u>	23b. DATE THEREOF <u>6-14-67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>ST. JOHN'S CEMETERY</u>	23d. LOCATION (City or Town) (County) (State) <u>DEAL ISLAND Som MD</u>
24. FUNERAL DIRECTOR <u>L. Webster Pruiett Anne Kid</u>		25a. REC'D BY REGISTRAR <u>JUN 19 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u>			

03883

STATE OF TEXAS

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove section papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH														
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201														
08866					CERTIFICATE OF DEATH					08864				
1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Somerset</u>									
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>			c. LENGTH OF STAY IN lb		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Venton</u> 19.2									
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Peninsula General Hospital</u>					d. STREET ADDRESS <u>Rt. 3 Box 318</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print) First <u>Ernest</u> Middle <u>R.</u> Last <u>White</u>					4. DATE OF DEATH Month <u>June</u> Day <u>21</u> Year <u>1967</u>									
5. SEX <u>male</u>		6. COLOR OR RACE <u>Negro</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>6/1/12</u>		9. AGE (In years last birthday) <u>55</u> yrs.		IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min <u>0</u>		IF UNDER 24 HRS. Hours <u>0</u> Min <u>0</u>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>General Laborer</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>				11. BIRTHPLACE (County & State, or foreign country) <u>Somerset Co. Md.</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		
13. FATHER'S NAME <u>Agusta White</u>					14. MOTHER'S MAIDEN NAME <u>Mary E. Smith</u>									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u> <u>2/15/44-4/2/46</u>				16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Agusta White</u> Address <u>Venton, Md. Rt. 3 #318</u>								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: 4222 IMMEDIATE CAUSE (a) <u>Congestive Heart Failure</u> DUE TO <u>Myocarditis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Not Known</u> (c) <u>—</u>										INTERVAL BETWEEN ONSET AND DEATH <u>3 weeks</u>				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Broncho pneumonia</u>										19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
20a. ACCIDENT WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)										
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u>—</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)								
21. I certify that (I) (this hospital) attended the deceased from <u>6/20/67</u> to <u>6/21/67</u> that (I) (we) last saw the deceased alive on <u>6/21/67</u> and that death occurred at <u>6:00</u> M, from causes and on the date stated above.														
22a. SIGNATURE <u>[Signature]</u>					ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED							
22c. PHYSICIAN'S NAME (Type) <u>[Signature]</u>					22d. ADDRESS <u>[Signature]</u>									
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>6/25/67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Grace Methodist</u>		23d. LOCATION (City or Town) (County) (State) <u>Venton Somerset Md.</u>								
24. FUNERAL DIRECTOR <u>Norma J. Stark</u>				ADDRESS <u>Marionette, Md.</u>		25a. REC'D BY REGISTRAR DATE <u>JUN 27 1967</u>		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>						

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

08867

08865

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>105 Lakeview Drive</u>				d. STREET ADDRESS <u>105 Lakeview Drive</u>			
3. NAME OF DECEASED (Type or print) <u>GEORGE REYNOLDS WHITE</u>				4. DATE OF DEATH Month <u>JUNE</u> Day <u>23</u> Year <u>1967</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>August 16, 1900</u>	
9. AGE (in years last birthday) <u>66</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>		IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Sales Manager</u>	
10b. KIND OF BUSINESS OR INDUSTRY <u>Automotive</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Salisbury, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>J. Edward White</u>	
14. MOTHER'S MAIDEN NAME <u>Lillie A. Riggs</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give year or dates of service)		16. SOCIAL SECURITY NO. <u>217-12-4100</u>		17. INFORMANT Address <u>Mrs. M. Elizabeth White (Wife)</u> <u>105 Lakeview Drive, Salisbury, Maryland</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Ca metastatic to brain</u> DUE TO (b) <u>Bronchogenic Carcinoma</u> (c) <u> </u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							INTERVAL BETWEEN ONSET AND DEATH <u>3 weeks</u> <u>3 months</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>N/A</u>			
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State) <u> </u> <u> </u> <u> </u>	
21. I certify that (I) (this hospital) attended the deceased from <u>April 13, 1967</u> to <u>6/23, 1967</u> , that (I) (the) last saw the deceased alive on <u>6/20, 1967</u> , and that death occurred at <u>5:15</u> M, from the causes and on the date stated above.							
22a. SIGNATURE <u>George H. Henning</u> M.D.				22b. DATE SIGNED <u>June 24/1967</u>			
22c. PHYSICIAN'S NAME (Type) <u>Dr. George Henning</u>				22d. ADDRESS <u>Ocean City Road, Salisbury, Maryland</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>June 26, 1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Parsons Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Salisbury, Maryland</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>HOLLOWAY & COMPANY, SALISBURY, MARYLAND</u>				25a. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 of this certificate should be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Page 28 of 30

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 should be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

08868		08866	
1. PLACE OF DEATH a. COUNTY Wicomico b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Salisbury c. LENGTH OF STAY IN 1b MARYLAND d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 217 Maryland Avenue		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) e. STATE Maryland b. COUNTY Wicomico c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Salisbury d. STREET ADDRESS 217 Maryland Avenue e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First LAURA Middle ELLEN Last WHITE		4. DATE OF DEATH Month JUNE Day 25 Year 19 67	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH November 8, 1884
9. AGE (In years last birthday) 82 yrs.		IF UNDER 1 YEAR Months 7 Days 17	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired- Registered Nurse Nursing		10b. KIND OF BUSINESS OR INDUSTRY Nursing	
11. BIRTHPLACE (County & State, or foreign country) Wicomico County, Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Lemuel Knowles		14. MOTHER'S MAIDEN NAME Martha E. Walker	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 219-07-6066T	
17. INFORMANT Mrs. Sara E. White (Daughter-in-law) Address Dodd Avenue, Rehoboth Beach, Delaware			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) arteriosclerotic Heart Disease 4300 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH several	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20e. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		2Db. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) N/A	
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 19 to 6-25 , 19 67 that (I) (we) last saw the deceased alive on 6-25 , 19 67 and that death occurred at 6 M, from the causes and on the date stated above.			
22e. SIGNATURE Dr. Wilber R. Ellis M.D.		22b. DATE SIGNED June 27 1967	
22c. PHYSICIAN'S NAME (Type) Dr. Wilber R. Ellis		22d. ADDRESS Salisbury, Maryland	
23e. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF June 28, 1967	23c. NAME OF CEMETERY OR CREMATORY Parsons Cemetery	23d. LOCATION (City, town or county) (State) Salisbury, Maryland
24. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY, SALISBURY, MARYLAND		25a. REC'D BY REGISTRAR JUN 28 1967	
		25b. REGISTRAR'S SIGNATURE Charles Judge	

WILSON & COMPANY, BALTIMORE, MARYLAND

June 28, 1907

Dr. Wilson & Co.

Baltimore, Maryland

Baltimore, Maryland

The location for the

WILSON & COMPANY, BALTIMORE, MARYLAND

June 28, 1907

Dr. Wilson & Co.

Baltimore, Maryland

Baltimore, Maryland

The location for the

WILSON & COMPANY, BALTIMORE, MARYLAND

June 28, 1907

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Baltimore, Maryland

Baltimore, Maryland

The location for the

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Item #9 Film #G390 7/6/67 pc

08863

CERTIFICATE OF DEATH

08867

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. LENGTH OF STAY IN 1b 5 Yrs.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 104 E. Isabella St.,		e. STREET ADDRESS 104 E. Isabella St.,	
3. NAME OF DECEASED (Type or print) CHARLES EDWARD WILLIAMS		4. DATE OF DEATH Month 6 Day 26 Year 19 67	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9/8/1886
9. AGE (In years last birthday) 81 yrs.		10. IF UNDER 1 YEAR Months Days	11. IF UNDER 24 HRS. Hours Min.
12a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman, Retired		12b. KIND OF BUSINESS OR INDUSTRY Stoves	
13. FATHER'S NAME Richard Williams		14. MOTHER'S MAIDEN NAME Ida Brian	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. -----	
17. INFORMANT Mrs. Dorothy Williams see sec #2		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarct DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic Heart Disease DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 3-2-19 67 to 6-26-19 67 that (I) (we) last saw the deceased alive on 5-20 19 67 , and that death occurred at 12:42 PM , from causes and on the date stated above.			
22a. SIGNATURE James L. Clifford		22b. DATE SIGNED 6-26-1967	
22c. PHYSICIAN'S NAME (Type) Dr. James L. Clifford		22d. ADDRESS Salisbury, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 6-28-1967	23c. NAME OF CEMETERY OR CREMATORY Parsons Cemetery	23d. LOCATION (City or Town) (County) (State) Salisbury, Maryland
24. FUNERAL DIRECTOR Hill Funeral Home Salisbury, Maryland		25a. REC'D BY REGISTRAR JUN 28 1967	
ADDRESS		25b. REGISTRAR'S SIGNATURE [Signature]	

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08870

08868

FOR STATE HEALTH DEPT

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Nanticoke		c. LENGTH OF STAY IN 1b Lifetime		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Nanticoke 221			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				d. STREET ADDRESS			
3. NAME OF DECEASED (Type or print) First HOBERT Middle EDGAR Last WILLING				4. DATE OF DEATH Month 6 Day 26 Year 67			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9-2-01	9. AGE (In years last birthday) 65 yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY merchant		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Hobert Willing				14. MOTHER'S MAIDEN NAME Bertie Willing			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO.		17. INFORMANT Bertie Willing, Nanticoke, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH Instant	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE Earl L. Royer, M.D.				22. DATE SIGNED June 27, 1967			
EXAMINER'S NAME (Type) Earl L. Royer, M.D.				Address (Street, City, Town, or county) 109 Camden Ave., Salisbury, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 6/29/67		23c. NAME OF CEMETERY OR CREMATORY Turners Cemetery		23d. LOCATION (City or Town) (County) (State) Nanticoke, Md.	
24. FUNERAL DIRECTOR Messick Funeral Home, Bivalve, Md.				25a. REC'D BY REGISTRAR JUN 30 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	

06330

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

08871

08869

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Wicomico</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. LENGTH OF STAY IN TB		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Eden</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Peninsula General Hospital</u>				d. STREET ADDRESS <u>R 7 D 2</u>			
3. NAME OF DECEASED (Type or print) <u>ROSA</u> First <u>LEE</u> Middle <u>WINDSOR</u> Last				4. DATE OF DEATH Month <u>JUNE</u> Day <u>14</u> Year <u>1967</u>			
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> 8. DATE OF BIRTH <u>Feb 21 1912</u>			
9. AGE (In years last birthday) <u>55</u> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>			
11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Isaac Windsor</u>			
14. MOTHER'S MAIDEN NAME <u>Essie Parks</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.			
17. INFORMANT <u>Harvey Windsor</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial infarction</u> DUE TO (b) <u>Congestive heart failure</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>2 hrs.</u> <u>Dubs.</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>diabetes mellitus</u>				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, form, factory, street, office bldg., etc.)			
20f. (City or town)		(County)		(State)			
21. I certify that (I) (this hospital) attended the deceased from <u>Jan 1966</u> to <u>6/14</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>6/14</u> , 19 <u>67</u> , and that death occurred at <u>12:30</u> M, from causes and on the date stated above.							
22a. SIGNATURE <u>[Signature]</u>		22b. DATE SIGNED <u>6/15/67</u>		22c. PHYSICIAN'S NAME (Type) <u>[Signature]</u>			
22d. ADDRESS		22e. MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>6/17/67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Oral Cemetery</u>			
23d. LOCATION (City or Town) <u>Oral MD</u>		(County)		(State)			
24. FUNERAL DIRECTOR <u>[Signature]</u>		25a. REC'D BY REGISTRAR <u>[Signature]</u>		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>			
DATE <u>JUN 19 1967</u>		25c. REGISTRAR'S SIGNATURE <u>[Signature]</u>					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

STATE OF TEXAS

17220

UNITED STATES DEPARTMENT OF THE INTERIOR
BUREAU OF LAND MANAGEMENT
LAND OFFICE
FORT WORTH, TEXAS

1961

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. They please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

08872

CERTIFICATE OF DEATH

08870

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Deer's Head State Hospital		d. STREET ADDRESS 312 Park Avenue	
3. NAME OF DECEASED (Type or print) First CHARLES Middle HERMAN Last WINGATE		4. DATE OF DEATH Month 6 Day 12 Year 1967	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11-11-1895
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) AUTO BODY MAN RTD		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years lost birthday) yrs. 71
11. BIRTHPLACE (County & State, or foreign country) Sussex Co. DELAWARE		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME BARCLAY WINGATE		14. MOTHER'S MAIDEN NAME ALICE MOORE WINGATE	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO. 222-09-7322	
17. INFORMANT Edna M. Wingate		Address Salis.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH 6-8 weeks
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from May 30 , 19 67 , to June 12 , 19 67 , that (I) (we) last saw the deceased alive on June 12 , 19 67 , and that death occurred at 1:30 PM , from causes and on the date stated above.			
22a. SIGNATURE C. H. Winnacott		22b. DATE SIGNED 6/12/67	
22c. PHYSICIAN'S NAME (Type) C. H. Winnacott, M. D.		22d. ADDRESS Deer's Head State Hospital, Salisbury, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF 6/16/67	23c. NAME OF CEMETERY OR CREMATORY odd Fellows	23d. LOCATION (City or Town) (County) (State) LAUREL Sussex DEL.
24. FUNERAL DIRECTOR William J. Edwards Georgetown, Md		25. REGISTRAR'S SIGNATURE Charles J. [Signature]	

15843

REPUBLIC OF CHINA

35732

1. The first part of the report is a general description of the project and its objectives. It includes a brief history of the project and a statement of the problem to be solved. The second part of the report is a detailed description of the methods used in the study. This includes a description of the experimental design, the data collection methods, and the statistical analysis. The third part of the report is a discussion of the results of the study. This includes a description of the findings, a comparison of the results with previous studies, and a discussion of the implications of the findings. The fourth part of the report is a conclusion and a list of references.

2. The first part of the report is a general description of the project and its objectives. It includes a brief history of the project and a statement of the problem to be solved. The second part of the report is a detailed description of the methods used in the study. This includes a description of the experimental design, the data collection methods, and the statistical analysis. The third part of the report is a discussion of the results of the study. This includes a description of the findings, a comparison of the results with previous studies, and a discussion of the implications of the findings. The fourth part of the report is a conclusion and a list of references.

3. The first part of the report is a general description of the project and its objectives. It includes a brief history of the project and a statement of the problem to be solved. The second part of the report is a detailed description of the methods used in the study. This includes a description of the experimental design, the data collection methods, and the statistical analysis. The third part of the report is a discussion of the results of the study. This includes a description of the findings, a comparison of the results with previous studies, and a discussion of the implications of the findings. The fourth part of the report is a conclusion and a list of references.

4. The first part of the report is a general description of the project and its objectives. It includes a brief history of the project and a statement of the problem to be solved. The second part of the report is a detailed description of the methods used in the study. This includes a description of the experimental design, the data collection methods, and the statistical analysis. The third part of the report is a discussion of the results of the study. This includes a description of the findings, a comparison of the results with previous studies, and a discussion of the implications of the findings. The fourth part of the report is a conclusion and a list of references.

5. The first part of the report is a general description of the project and its objectives. It includes a brief history of the project and a statement of the problem to be solved. The second part of the report is a detailed description of the methods used in the study. This includes a description of the experimental design, the data collection methods, and the statistical analysis. The third part of the report is a discussion of the results of the study. This includes a description of the findings, a comparison of the results with previous studies, and a discussion of the implications of the findings. The fourth part of the report is a conclusion and a list of references.

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08873

08871

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY _____	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 3014	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) DOA Peninsula General Hospital		d. STREET ADDRESS 2225 Madison Ave.	
3. NAME OF DECEASED (Type or print) First JOSEPH Middle C. Last WORTHAN		4. DATE OF DEATH Month 6 Day 4 Year 1967	
5. SEX Male	6. COLOR OR RACE AA	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Mar. 5, 1913 53 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years lost birthday) 53 yrs.
11. BIRTHPLACE (State or foreign country) N. Carolina		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes World War II		16. SOCIAL SECURITY NO.	
17. INFORMANT Jack Worthan Address 1423 Carowell St			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Fracture of cervical spine 8254 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Crushed chest (c) sudden			INTERVAL BETWEEN ONSET AND DEATH sudden
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Involved in one car accident, driver unknown.	
20c. TIME OF INJURY Month, Day, Year 12:35 6-4-67 19 Hour XXX p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> of work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Route 50	20f. (City or town) (County) (State) Salisbury, Wicomico, Md.
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Earl L. Royer, M.D. EXAMINER'S NAME (Type) 409 Camden Ave., Salisbury, Md.		22. DATE SIGNED June 5, 1967	
23a. BURIAL, CREMATION, REMOVAL (Specify) Buried June 9/67	23b. DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORY Salisbury Natl Cem	23d. LOCATION (City or town) (County) (State) 5501 Frederick Ave
24. FUNERAL DIRECTOR Elliott Funeral Home, Baltimore, Md.		25a. REC'D BY REGISTRAR DATE JUN 16 1967	25b. REGISTRAR'S SIGNATURE Charles Judge

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-1. Pages 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil, in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08874

08872

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Salisbury	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. LENGTH OF STAY IN 1b 30 4	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) DOA Peninsula General Hospital		d. STREET ADDRESS 2225 Madison Ave.	
3. NAME OF DECEASED (Type or print) First LEORA Middle H. Last WORTHAN		4. DATE OF DEATH Month 6 Day 4 Year 1967	
5. SEX F	6. COLOR OR RACE AA	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5-13-35
9. AGE (In years last birthday) 32 yrs.		10. IF UNDER 1 YEAR Months 1 Days 19 Hours 19 Min 19	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY Domestic	
11. BIRTHPLACE (State or foreign country) Lenora Co. N.C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Joseph Hines		14. MOTHER'S MAIDEN NAME Leona Lucas	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, for, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT Leona Hines		Address 812 East Hines St. Wilson N.C.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Fracture of Skull DUE TO (b) 825.4 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Involved in one car accident, driver unknown.	
20c. TIME OF INJURY Month, Day, Year Hour 12:25 p.m. 6-4-67 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Route 50	
20f. (City or town) (County) (State) Salisbury, Wicomico, Md.		21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>	
22. DATE SIGNED June 6, 1967		23. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county)	
24. ACTUAL SIGNATURE Earl L. Royer, M.D. EXAMINER'S NAME (Type) 409 Camden Ave., Salisbury, Md.		25. BURIAL, CREMATION, REMOVAL (Specify) Burial	
26. DATE THEREOF 6-11-67		27. NAME OF CEMETERY OR CREMATORY Rest Haven	
28. LOCATION (City or town) (County) (State) Wilson Wilson N.C.		29. REC'D BY REGISTRAR DATE JUN 8 1967	
30. REGISTRAR'S SIGNATURE Charles Judge		31. FUNERAL DIRECTOR Barrett B. Folley	

STEEL

47300